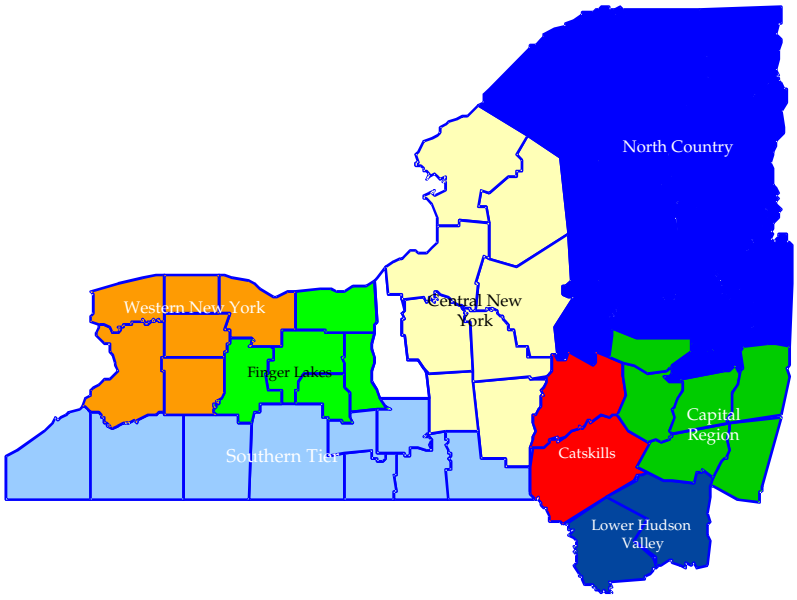
ROBERT W. CAREY QUALITY AWARD APPLICATION



VA Healthcare Network Upstate New York – Network 2
March 20, 2001

Robert W. Carey Quality Award Application

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ORGANIZATION OVERVIEW

Between 1995 and 2000, Network 2 successfully transformed its health delivery system, providing services to significantly greater numbers of veterans while achieving excellence in health care quality and customer satisfaction. This transformation was achieved through a systematic process by which well-defined performance targets were established in those areas crucial to organizational success **(Key Drivers- Fig 0.1)**.

Fig 0.1

4 KEY BUSINESS DRIVERS

- **Generate Significant Patient Growth**
- **Provide Optimum Health Care Value**
- **Achieve Outstanding Customer Service**
- **Deliver Excellence in Quality of Care**

Also critical was the establishment of an innovative Care Line structure that permitted rapid systems transformation, through the development of network-wide goals and operational strategies. The essence of Network 2's successful transformation was the ongoing monitoring of key performance indicators, that would be readily communicated through the entire Upstate New York Network. These indicators were identified as critical determinants of organizational success **(Fig 0.2)**:

Significant investments in information and data technology were introduced at the outset, providing senior leaders and staff at all levels of the organization with the necessary tools to assess organizational progress and achieve measurable improvements in performance. The intent is to build a world class health delivery system by achieving the highest levels of quality and customer service, within both VA and the private sector. We define world class as achieving the 90th percentile nationally for all standardized measures of patient satisfaction and quality. Organizational Principles are presented in **Fig 0.3**.

Fig 0.3

ORGANIZATIONAL PRINCIPLES

- **SET PERFORMANCE EXPECTATIONS THAT FAR SURPASS ALL CURRENT HEALTH SYSTEMS**
- **BENCHMARK WITH THE BEST HEALTH CARE & NON-HEALTH CARE ORGANIZATIONS**
- **EMPOWER ALL STAFF THROUGH SELF-DIRECTED ACTIONS**
- **ENCOURAGE & REWARD CREATIVITY AND TEAMWORK**

Organizational Improvements: The reengineering of Network 2's health delivery system was based upon the wide deployment of these transformation principles and the development of shared accountability for achievement of targeted goals. Between 1996 and 2000, Network 2 achieved or approached VA best practice in each of the four areas deemed crucial to organizational success (key business drivers). Specifically, a 42.1% increase in patients treated equaled the 2nd greatest increase among 22 VA networks **(Fig 7.5C)**, an achievement especially significant for an area experiencing disproportionate veteran population losses. These achievements were realized despite VA headquarters' projections of sharp patient reductions for Network 2, in favor of sun-belt networks. With regard to the 2nd key driver, cost

DETERMINANTS OF ORGANIZATIONAL SUCCESS

Key Business Drivers	Indicators of Success	Desired Outcomes
Significant Patient Growth	Achieve Optimum Growth in New Patients, Patient Retention, and Market Penetration	♦ Generate Maximum Revenue ♦ Provide Benefits to Greater Numbers of Veterans
Excellent Health Care Value	Generate Optimum Clinical and Administrative Cost and Staffing per Patient;	♦ Redirect Savings To Develop New Programs ♦ Expand Treatment Capacity
Outstanding Customer Service	Achieve Excellent Outpatient And Inpatient Satisfaction Scores; Minimize Patient Problems; Reduce Clinic Wait Times	♦ Retain a Greater % of Patients ♦ Attract New Patients ♦ Improve Timeliness of Care
Excellence in Quality	Generate top Scores in Preventive Health, Chronic Disease and Mental Health Follow-Up Indices	♦ Provide Excellent Preventive Health ♦ Improve Health Status of Veterans ♦ Improve Overall Community Health

Fig 0.2

per patient was reduced by 39.8% since 1996, adjusting for inflation, the greatest reduction in unit cost among all 22 networks **(Fig 7.2B)**. This transformation in patient growth and cost effectiveness resulted from expansion of outpatient and community based clinics , improved use of alternate treatment settings and through improved delivery practices, including reduction of unnecessary hospitalization **(Fig 7.2G)**. In accordance with the third key driver achieving outstanding customer service, Network 2 has achieved the 2nd highest overall scores in 2000 **(Fig 7.1F,K)**, achieving the greatest improvement VA-wide since 1995 **(Figs 7.1F)**. In support of the fourth identified measure of organizational success, excellence in quality, Network 2 achieved VA best practice in Mental Health Follow-up in 1999 and 2000 **(Fig 7.5B)**, while achieving numerous best practices related to preventive measures and clinical practice guidelines **(Fig 1.2).** Network 2 ranked first among all 22 networks in a composite performance index, achieving an extraordinary level of consistency unmatched by any other network of **(Figs 1.6, 7.5B).** This achievement in setting Network 2 apart from VA nationally is most significant in view of VA's **A rating** from Congress, received in October 2000, a rating matched only by the Department of Transportation **(Fig.0.4)**

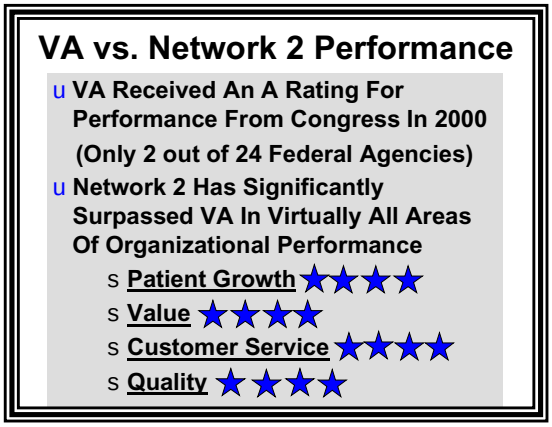


Fig 0.4

1. Organization Description: The VA Healthcare Network Upstate is an integrated health care delivery system, serving veterans in 47 counties in New York State as well as two in Northern Pennsylvania. Network 2 provides a full array of inpatient, ambulatory and long term care services, including a full range of medical, surgical and mental health specialty services. This health care network provides inpatient facilities at six locations including Albany, Batavia, Bath, Buffalo, Syracuse, and Canandaigua, while operating a network of 29 community-based clinics throughout the region. The VA Healthcare Network Upstate New York maintains a Care Line Matrix structure through which a full range of health care services are provided to veteran patients **(Fig 0.5)**.

In contrast to traditional hospital and network delivery systems, line and budgetary authority are assigned to Care Lines, arranged horizontally across a network of Medical Centers, clinics and nursing home care units. Initiated in 1997, this reorganization was designed to create an effective integrated delivery system, which promotes one standard of care across the Network **(Fig 0.5)**.

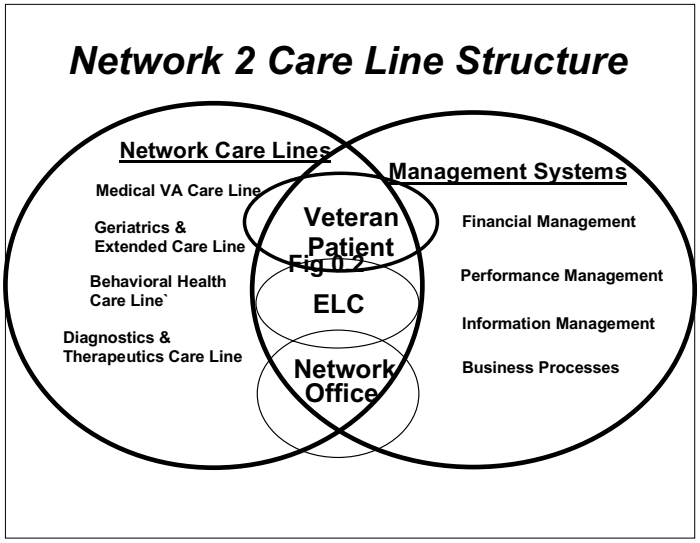


Fig 0.5

The implementation of Network-wide care lines has redirected attention to network-wide rather than facility-based needs, and has promoted a significant transformation in cost effectiveness, patient growth, customer satisfaction and quality for Upstate New York's veterans.

Mission, Vision, Values:

Mission: We are committed to providing excellent health care services to the veterans of Upstate New York. These services will be provided with dignity and compassion in an environment that promotes trust and respect.

Vision: We will be recognized as the healthcare provider of choice in Upstate New York, providing care of exceptional quality and value. We will be known for our ease of access, customer satisfaction, excellent clinical quality and the improved health status of our enrolled population. We will foster partnerships with our

patients and other stakeholders in the decision-making process.

Values: Trust, Respect, Commitment, Compassion and Excellence

The percentage of the Network 2's veteran population treated has increased from 12.6% in 1997 to 17.7% in 2000, achieving the 3rd highest market penetration behind Network 8 (Bay Pines) and Network 18 (Phoenix) **(Fig 7.1A)**. Network 2 has a principal market segment composed largely of male veterans with limited income, although a growing number of women veterans continue to receive care. 48% of Network 2 enrollees are over age 65; the average user income is $16,481 with 75% earning less than $20,000 annually and 61% of users carrying no health insurance.

Employees: Network 2 currently employs over 4919 staff, with 55% involved in direct patient care activities, 28% administration, and16% involved in facilities management. Network 2 maintains the 3rd lowest administrative cost per patient, which has resulted from reengineering of work processes **(Fig 7.2E)**. The staff is supplemented with over 4,000 volunteers who have contributed over 545,000 man-hours of service in the past year. Network 2 has active labor partnerships with the Service Employees International Union, American Federation of Government Employees, and the New York State Nurses Association. The number of staff by category of employment is provided in **(Fig 0.6)**.

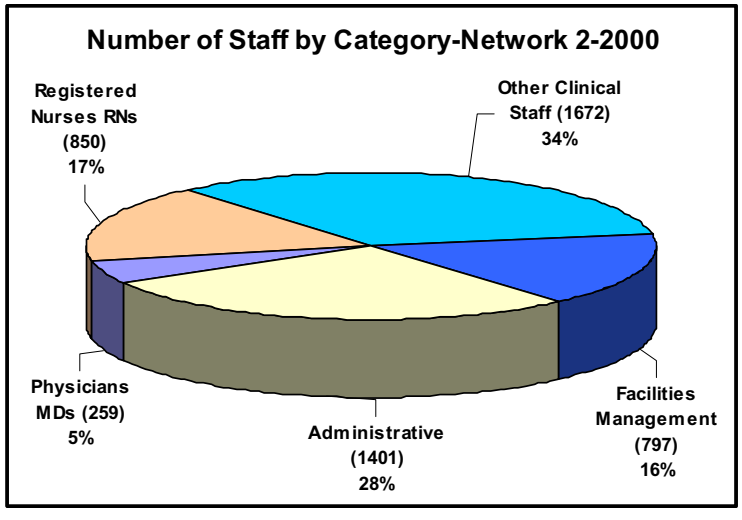


Fig 0.6

Network 2 maintains three acute/urgent care facilities (Buffalo, Syracuse, and Albany) that provide a full range of acute medical, surgical and mental health services. The average age of the Network 2 Medical Centers is 45.2 years. This creates the need for ongoing costly maintenance and needed renovations to accommodate the delivery of preferred outpatient services. Network 2 has invested in a telecommunications infrastructure capable of supporting technologically advanced applications including full data base integration, a computerized patient medical record system, telemedicine and extensive video teleconferencing **(Fig 5.3)**.

Voluntary Accreditation and Malcolm Baldridge-based Awards

Network 2 has led the Department of Veterans affairs in seeking voluntary accreditation, applying the highest standards of quality, well beyond traditional VA and Joint Commission (JCAHO) requirements. Network 2 received VA's first annual Quality Achievement Recognition Grant Award in 1999, achieved fourth place for the 2000 Robert Carey Quality Award and was the only Network to apply for the Malcolm Baldridge Quality Award in 1999 & 2000. We have continually incorporated written status reports from the Kizer Quality, Carey and Baldridge application processes.

Network 2 was the first Network to seek Accreditation from the National Committee on Quality Assurance (NCQA), the primary accrediting body of health maintenance organizations, receiving a two-year accreditation in 1999 with a rating of commendable. Only Networks 2 and 15 (Kansas City) have received NCQA accreditation. In addition, Network 2 was the first network to seek and achieve accreditation from the Committee on Accreditation of Rehabilitation Facilities (CARF) for its rehabilitation and chemical dependency programs. CARF accreditation has been received or is in process for all facilities including Albany, Bath, Buffalo, Canandaigua and Syracuse. Accreditations are as follows:

- Joint Commission on Accreditation of Health Care Organizations (JCAHO). 3 year Hospital Accreditation scores, received in 2000, are as follows: Albany (86), Bath (94), Buffalo (91), Canandaigua (92) and Syracuse (87)
- National Committee for Quality Assurance (NCQA) 2 Year (Rating = Commendable)

- Committee for the Accreditation of Rehabilitation Facilities (CARF)-All Sites
- Occupational Safety & Health Administration
- Nuclear Regulatory Commission (NRC)
- CAP (College of American Pathologists)

The VA Healthcare Network Upstate New York is one of twenty-two Veterans Integrated Service Networks (VISNs) nationwide that constitute the Veterans Health Administration (VHA), the nation's largest integrated health care system. With a budget of more than $467 million, Network 2 provides health care to approximately 116,000 veterans through 5 medical centers, 29 community based clinics and 6 nursing home care units. In addition to its medical care mission, the veterans healthcare system is the nation's largest provider of graduate medical education and one of the nation's largest medical research organizations. VA also provides backup to the Department of Defense and the National Disaster Medical System.

Network 2 has introduced plans to assure that full integration of health care services is provided to veterans. This will be accomplished through the availability of primary care programs at all sites including Community Based Outpatient Clinics (CBOCs), greater involvement of geriatrics and mental health staff on Primary Care Teams, and expanded partnership with community organizations. Network 2 maintains staffed programs in the inpatient, outpatient, and home care settings while also maintaining nursing home care unit beds, through either VA-operated or contract nursing homes within the community. Network 2 will strive to provide a consistent level of care to the veteran population through greater uniformity and standardization of services, greater application of clinical practice guidelines and disease management protocols and through the establishment of standards for all clinical disciplines.

2. Patient/Customer and Health Care Market Requirements: Network 2's customers are veteran patients, who require a full range of medical, surgical, behavioral health and long-term care services. These services require easy accessibility throughout Upstate New York **(Fig 3.3)**, are provided in a timely and courteous manner, and are offered in a manner which elicits the highest levels of patient satisfaction. Network 2 will be successful to the extent that patient growth and retention are optimal, by striving for world-class customer service and excellence in health care quality. Services will be provided for a growing number of women veterans, including vital screening programs **(Fig 7.5F-G)**.

Patient/Customer market Requirements are determined by incorporating information from diverse sources including customer satisfaction results, veteran service organizations, patient complaint data and Quick Card responses. The Network 2 Customer Service Council continually solicits information from patient groups in order to improve access to care, timeliness and all facets of patient satisfaction. Through listening and learning techniques, a wide range of new products and services were introduced that will further improve customer service. Information has also been obtained through collaboration with other VA networks in order to share best practices and continually improve performance. Network 2 has hosted best practice workshops for visiting staff from other networks and has submitted many initiatives for inclusion in a Customer Service Best Practice Guidebook. Performance targets designed to exceed customer expectations, have been established through 2006.

3. Supplier and Partnering Relationships: Network 2 maintains effective relationships with vendors and community organizations to assure timely and effective delivery of services as well as optimum use of available resources. Effective negotiations with vendors and suppliers have produced considerable cost savings through contract standardization **(Fig 7.4A)**. Effective sharing agreements with community organizations have produced additional revenue, by making effective use of available resources **(Fig 7.4B)**. Network 2 continues to work with vendors in arranging group-purchasing agreements, resulting in significant cost savings **(Fig 7.4D)**. Timely provision of mail-out prescription services has resulted through effective contractual arrangements, with improved turnaround times **(Fig 7.4C)**.

4. Competitive Situation: Network 2 operates in an environment of declining veteran population, in which VA budget appropriations are apportioned in accordance with the numbers of patients receiving care. Financial success is based

on the extent to which veteran population losses are offset by successful patient enrollment efforts and improved health delivery processes. VA Healthcare Network Upstate New York competes with other networks for a percentage of the VA budget, especially networks in sun-belt areas in which the veteran population is increasing. Enjoying one of the largest turnarounds in financial performance, Network 2 has successfully expanded its patient base, despite significant veteran population reductions. Care Line reengineering efforts have produced network-wide improvements in efficiency, patient satisfaction and quality as measured by standardized measurements. Network 2 also competes with local health care providers and hospitals for veteran patients and must strive to deliver care that adheres to the highest standards of timeliness, quality and patient satisfaction. Network 2 must also provide patient care amenities and facilities that are competitive with local communities.

Improvements in Network productivity in FY 2000 are largely attributable to improved health delivery practices, including reduced unit costs, improved use of alternate treatment settings and a decrease in unnecessary hospitalization. Plans for significant expansion of vital programs and services is largely attributable to an improved financial situation in FY 2001. Improved productivity and corresponding unit cost reductions have generated enhanced performance as measured by the Veterans Equitable Resource Allocation (VERA) Model, the principal determinant of Network budget allocations. In accordance with the proposed Congressional Budget for Fiscal Year 2001 Network 2 received a general operating budget of $516.8 million, an increase of approximately $49.3 million or 10.5% over the prior year **(Fig. 7.2A)**.

5. Organizational Directions: Network 2 will continue to refine its health delivery system, developing its data systems through an integrated medical record. The intent is to provide greater accuracy to enhance patient information. Network 2 is embarking on profound improvements in health delivery through advancement of disease management programs and greater use and application of clinical practice guidelines. This represents a profound enhancement in health delivery, through standardization of practices, while encompassing and applying a wider body of health care knowledge now available for providers. Network 2 is committed to improving the health status of the veteran population through greater Mental Health and Geriatric support to Primary Care Teams, computerized imaging and through improved outreach programs for high risk veteran groups. Partnerships will be forged with community organizations, in order to optimize the use of health care resources, while assuring that state of the art services are available to veteran patients.

Network 2 is also committed to improving customer service including reductions in waiting times, standardization of care through disease management programs and clinical guidelines. Access to care is being improved through Virtual Help Desk, Network 2's Web Page and through a 24-hour telephone help desk. Network 2 has undergone an integration of its patient database among all facilities and community based clinics to improve continuity of care and timely access to patient information from any location.

TO DEVELOP AND MAINTAIN A WORLD CLASS HEALTH CARE SYSTEM

- **To Excel in All Areas of Importance to the Organization**
- **Achieve the Highest Levels of Quality and Patient Satisfaction**
- **Develop Measurable Targets and Goals for Superior Performance**
- **Achieve Shared Accountability for Goal Attainment**

Fig 0.7

1.0 ORGANIZATIONAL LEADERSHIP

1.1a Leadership Direction:

The VA Healthcare Network Upstate New York is a state of the art health care system intent on delivering world class quality care, defined as providing the 90th percentile in quality and patient satisfaction. Our senior leaders are committed to the following principles, which they communicate and apply on a daily basis **(Fig 1.1):**

SENIOR LEADERSHIP PRINCIPLES

- SET PERFORMANCE EXPECTATIONS THAT FAR SURPASS ALL CURRENT HEALTH SYSTEMS
- EMPOWER ALL STAFF THROUGH SELF-DIRECTED ACTIONS
- DEVELOP SHARED ACCOUNTABILITY TO TRANSFORM THE ORGANIZATION
- RECOGNIZE AND REWARD ALL STAFF

Fig 1.1

Network 2 was the first VA Network to remove the traditional hierarchy associated with health care organizations and replace it with a Network – wide Care Line structure. Designed in 1997, this matrix design assigns programmatic responsibility to Care Lines arranged horizontally across a network of medical centers and outpatient clinics. Benefits include a high degree of collaboration and shared accountability as well as the emergence of new leaders previously hidden by traditional hierarchies. This structure, combined with the principles of empowerment, collaboration and superior performance, has produced VA's most dramatic performance as follows (**Fig 1.2):**

RESULTING ACCOMPLISHMENTS

- VA's GREATEST IMPROVEMENT IN QUALITY & PATIENT SATISFACTION
- VA's GREATEST FINANCIAL TURNAROUND & PERFORMANCE
- BEST PRACTICES IN: Influenza Immunizations, Mental Health Follow-Up, Diabetic Management, Tobacco Screening, Major Depression Screening, Alcohol Screening

Fig 1.2

The Network Director, Frederick L. Malphurs, is responsible for all care provided throughout the Network and is accountable to the Undersecretary for Health, Thomas Garthwaite MD. Senior leadership within Network 2 consists of Network Care Line Directors, Medical Center Directors and Network staff who work in close collaboration to set the strategic direction for the organization, actively design the organizational structure and processes, and assure superior performance. Our Senior leaders are actively involved with all levels of the work force, communicating, teaching and modeling the behaviors that produce outstanding patient care and organizational performance **(Fig 1.4)**.

1.1a(1) Organizational Values & Expectations:

Our leaders are personally involved in the formulation of the Mission, Vision and Values of Network 2, spending several months in discussion and refinement, and presenting them to the Executive Leadership Council (ELC) for final approval. Once approved, Care Line leaders, Medical Center Directors and other senior leaders personally discuss them with their staff at town and staff meetings, post them in highly visible places within each building and community-based clinic and distribute them with ID badges. Goal sharing (Fig 2.6) and interactive planning (Fig. 2.2) are two processes which require direct championing by senior leaders as well as active staff participation at all levels. Monthly Executive Leadership Council (ELC) meetings are structured around each of the 7 Malcolm Baldridge sections. Senior leaders have collaborated to identify the principal determinants of organizational success, issuing them as Key Business Drivers **(Fig 1.3)-Factors which will enable Network 2 to achieve World Class status by 2004** (achieving the 90th percentile in National Quality and Patient Satisfaction Scores)

KEY BUSINESS DRIVERS

1. GENERATE SIGNIFICANT PATIENT GROWTH
2. PROVIDE OPTIMUM HEALTH CARE VALUE ($)
3. ACHIEVE OUTSTANDING CUSTOMER SERVICE
4. DELIVER EXCELLENCE IN QUALITY OF CARE

Fig 1.3

Communication tools include web pages, e-mails posters and booklets and are used to convey the message of mission, vision, values and organizational goals. However the principal means of transmission is direct communication

from each senior leader, each of whom communicates directly with staff, embodies these principles and leads by personal example. Senior leaders' direct involvement in promoting values and expectations are presented in **Fig.1.4**.:

Network 2's profound successes in patient growth, financial performance, customer service and quality is firmly rooted in its results-driven management, driven by employee empowerment to take action and the wide availability of state of the art data analytical tools **(Fig 1.4; Cat 1.1b(1)&4.1a(1))**.

ESTABLISHING & DEPLOYING VALUES & EXPECTATIONS

	ESTABLISH	*COMMUNICATE*	*DEPLOY*
Organizational Values	Development of Mission, Vision & Value Statements and Key Business Drivers.	Mission, Vision Value Posters; Town & Staff Meetings; Meeting with the Director(s); ID Badges; Executive Leadership Council (ELC); Transforming Systems Performance & Quality (TSPQ); Local Leadership Council (LLC); Town & Staff Meetings, Web Page.	Goalsharing Program; Pulse Points; Decision Support Objects; VSO meetings; Staff Performance Standards; High Performance Development Model (HPDM); Individual Development Plans (IDPs); Employee Orientation; Employee Newsletter, Web Page.
Performance Expectations	Quantifiable performance measures linked to Key Business Drivers; Employee Performance Standards; Establishment of stretch goals; Projections on future performance expectations	Performance measures and expectations are communicated at ELC, LLCs, VSO meetings, TSPQ, Union Meetings, and staff meetings & Town Forums to reach front line staff.	Network, Care Line & Medical Center; Goalsharing; Staff Performance Standards; HPDM; Performance results posted in Pulse Points & Decision Support Objects (DSOs); Employee Orientation
Balance/Value for Patients & Stakeholders	Patients, Veterans Service Organizations, Labor & Community partners assist in developing Key Business Drivers. Multiple listening & learning posts; Performance expectations & measures ensure optimal balance between customer & stakeholder needs	Patients and Stakeholders are members of various councils including, ELC, Community Advisory Boards, Management Advisory Council (MAC), and the Union Council. Senior leaders utilize the MAC and Community Advisory Board as a marketing tool to communicate changes or improvements in services and benefits.	Annual *Report to the Community* highlights programs and performance on key business drivers and patient/stakeholder expectations; Quarterly Patient Newsletter highlights new, or changes in, processes, benefits, & programs. Hardcopy reports of each are mailed to veterans and stakeholders.

Fig 1.4

The Executive Leadership Council (ELC) Web Page, applies an Employee Collaboration Tool (ECT) to solicit input from staff in all leadership areas. A Strategic Planning Webpage similarly solicits employee involvement in developing goals and programs, demonstrating senior leadership's commitment to wide employee involvement in pursuing Network 2's mission. Achieving 100% staff involvement in goal sharing (5.1a3, 4) (winning OPM's Pillar Award), the introduction of an ELC and strategic planning websites for employees, coupled with VA's most outstanding improvement scores and results in 2000, are testimony to senior leaders' commitment to the organization's stated goals

Crucial to organizational success is the application of VA's most advanced data system, Decision Support Objects (DSOs), developed within VISN 2, allowing senior leaders and other staff to instantly evaluate organizational progress for over 100 data elements **(Fig. 1.5)**:

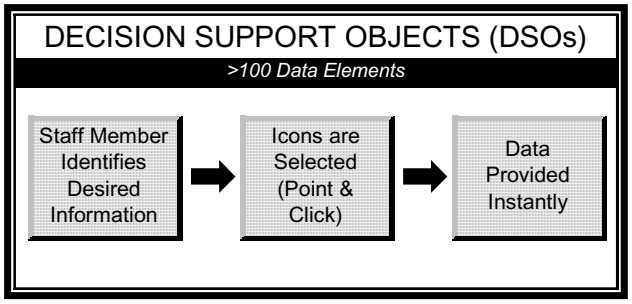


Fig 1.5

Network 2 has surpassed all VA networks in performance improvement since 1996, while achieving VA's highest composite scores for 2000. While the VA received an A rating for performance from Congress in October 2000, (only 2 out of 24 federal Agencies), Network 2 significantly surpassed VA in key areas of organizational importance (addressing all 4 key drivers), ranking among the top 3 out of 22 networks for **6 out of 6** key performance areas. No other network ranked among the top 3 for more than **2 out of 6** areas **(Fig. 1.6):**

FIRST RANKING AMONG ALL 22 VA NETWORKS in 2000

Average Rank for 6 Performance Measures
(Out of 22 Networks)

- **Patient Growth**
- **Cost**
- **Patient Satisfaction**
- **Clinic Waits**
- **Prevention Index**
- **Mental Health Follow-Up**

VISN	VISN Location	AVG. Rank (Out of 22)
2	Albany	2.67
19	Denver	6.50
15	Kansas City	8.33
21	San Francisco	8.33
16	Jackson,MS	9.00
20	Portland	9.50
4	Pittsburgh	9.83
18	Phoenix	10.33
7	Atlanta	10.50
13	Minneapolis	10.50
8	Bay Pines	10.67
14	Omaha	11.83
3	Bronx	12.33
5	Baltimore	12.33
9	Nashville	13.50
11	Ann Arbor	13.50
1	Boston	13.83
6	Durham	13.83
10	Cincinnati	14.67
17	Dallas	15.83
12	Chicago	16.67
22	Long Beach	18.50

Fig 1.6

1.1a(2) Empowerment & Learning:
Network 2's successes since 1996 are rooted in the wide dissemination of measurable performance expectations, coupled with employee empowerment to participate in key processes and take action. Employee empowerment is aided by the application of web-based employee collaboration tools including ELC and Strategic Planning web pages, and wide employee involvement in Interactive Planning Processes **(Fig 2.2).** 100% staff involvement in Goal Sharing **(Fig 2.6)** assures universal participation in not only adhering to the goals of the organizations but also in the development of those goals. All 5000 employees participate in over 1000 teams in which staff develop their own unit-level goals in accordance with the goals of the organization. Empowerment is illustrated in the flow chart at right **(Fig 1.7):**

Fig 1.7

Network 2 leaders embrace CQI principles to quickly respond to changing needs of customers and/or health care trends, by creating an environment for organizational and staff learning. Learning opportunities permeate Network 2 and are encouraged at the individual, unit and organizational levels. Organizational learning opportunities are identified through patient and stakeholder feedback, research activities, analysis of performance measure results, accreditation reviews and other feedback reports **(Fig 1.5)**. Through staff meetings, committee involvement and employee suggestion programs, our staff are encouraged to share ideas and best practices to identify opportunities for improvement and innovative solutions **(Cat 5.1a(5))**. As a result of patient feedback, organization learning led to the development of the Veterans Service Center, a centralized point for patients to obtain information on services, benefits, billing and general questions.

Our senior leaders facilitate learning through diverse means as described in **Fig 1.8.** Employee Individual Development Plans (IDPs) are encouraged to strengthen the skills of our staff. Senior Leaders recognize the value of staff and organizational learning to improve healthcare quality, enhance an environment for creativity and to develop a more satisfied and multi-skilled workforce. As such, senior leaders support an interactive strategic planning process, involving a maximum number of staff at every level within the Network **(Figs 2.2, 2.3).** Network 2's successful

SENIOR LEADERS –LEARNING & EMPOWERMENT

	Senior Leaders:	Application/Initiative:
Reinforce Empowerment and Innovation	˙ Staff participation on local & network committees ˙ Network Councils empowered to set direction ˙ Employees empowered to resolve complaints ˙ Brainstorming Retreats ˙ Research & Benchmark comparisons ˙ Systems review & development of creative solutions ˙ Continuous evaluation of key/support processes Fig. 6.1	˙ Community Based Clinics ˙ IHI Collaborative - Waits & Delays ˙ Customer Service Council established ˙ Veterans Service Center established ˙ Phantom Shopper initiated ˙ Greeter Program initiated ˙ Goalsharing Program implemented
Encourage Organizational Learning	˙ Continuous analysis of performance measures results ˙ Sharing of information/knowledge ˙ Embrace CQI principles ˙ Celebrate Successes ˙ Recognize & learn from Noble Failures ˙ Identification & Deployment of Best Practices ˙ Patient & Stakeholder Feedback ˙ Comparisons to Benchmarks	˙ Best Practice Deployment of CDI/PI ˙ Feedback reports: Carey & QARG ˙ Goalsharing Program ˙ Root Cause Analysis Process ˙ Interactive Planning Process ˙ IHI Collaborative – Waits & Delays ˙ Pulse Points ˙ Decision Support Objects
Encourage Staff Learning	˙ Sharing of knowledge and expertise ˙ Dedicated Funds for educational opportunities ˙ Establishment of a Network Education Council ˙ Deployment of HPDM/core competencies ˙ 360 Evaluations ˙ Continuing Education as a key support process	˙ Continuing Education Performance Standard ˙ On the job training forums ˙ Staff meetings/committee involvement ˙ Coaching & Mentoring Program ˙ Employee Newsletter ˙ Individual Development Plans (IDPs)

Fig 1.8

transformation from a hospital-based system to an integrated health care Network is a result of a participative planning process involving all employees and leaders. Assuring maximum staff development is crucial to Network 2's continued success, and will permit the realization of the foremost goals—To achieve world class status by 2004. Staff Development Principles, practiced daily by senior leaders, are identified in **Fig 1.9:**

OPTIMUM STAFF DEVELOPMENT

- CONTINUING EDUCATION
- EMPOWERMENT TO TAKE ACTIONS
- HIGH PERFORMANCE DEVELOPMENT MODEL
- GOAL SHARING PROGRAM
- INTERACTIVE PLANNING
- COACHING & MENTORING
- WEB-BASED EMPLOYEE COLLABORATION TOOL
- REWARD & RECOGNITION

Fig 1.9

1.1a(3) Direction & Future Opportunities: Senior leaders have developed the overall goal of becoming a world class health care provider by 2004, achieving the 90th percentile in National Quality and Patient Satisfaction Scores. This will be accomplished by benchmarking with the best organizations in the world, both within and outside of health care, while empowering staff to actively assist the organization in realizing its fullest potential. Senior leaders set the organizational direction by analyzing a full range of information to determine strategic goals and operational objectives using several techniques including trending analysis, projections, comparisons and cause and effect relationships. Sources of information include analysis of prior performance measure results, cost, workload and quality data, customer feedback, and analysis of the internal and external environment. Planning input is broadly solicited from patients and stakeholders through the Network 2 Website, town meetings, labor meetings, forums with VSOs, such as the Management Assistance Council, and congressional representatives. Primary responsibility for setting organizational direction and identifying potential opportunities resides with the Executive Leadership Council (ELC) which functions as Network 2's governing body. Council membership consists of representation from internal and external stakeholders, Labor, VSOs, Director of Veterans Benefits and senior leadership. The ELC develops the mission, vision, values and strategic objectives. The following blue print has been established to guide Network 2 toward world class status **(Fig. 1.10)**:

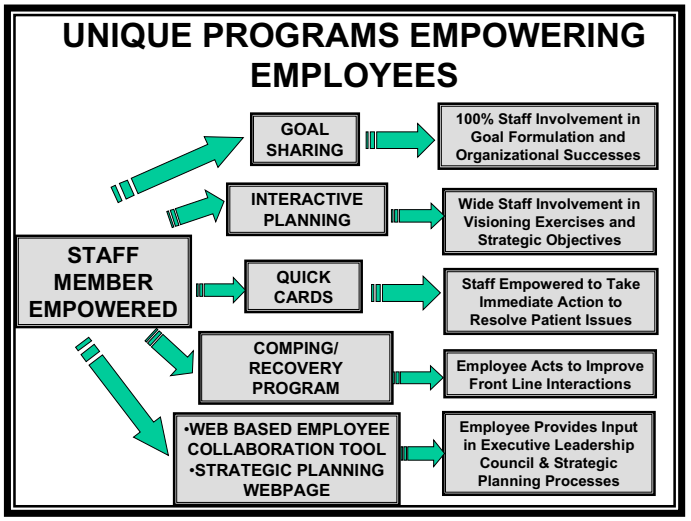
Fig 1.10

HOW NETWORK 2 WILL ACHIEVE WORLD CLASS STATUS BY 2004

•Past 4 Years 1996-2000	STRATEGIES	•Next 4 Years 2001-2004
•Greatest Improvement in Staff Productivity Among 22 Networks • 2nd Highest Patient Growth •2nd Best Patient Satisfaction Scores • 3rd Best Clinic Waiting Times • Best Mental Health Follow-up	u Superior Performance Targets u Benchmarking with the Best Organizations u Interactive Planning u Goal Sharing u Empowerment u On-Demand Learning u Maximum Staff Involvement	•90th Percentile in National Patient Satisfaction Scores •90th Percentile in National Prevention, Chronic Disease and Mental Health Indices •90th Percentile in National Clinic Waiting Times

Unlike other organizations which deploy goals set by senior leaders, Network 2 has proactively sought to involve staff in the actual formulation of the strategic direction, thereby developing a vested interest on the part of all staff in attaining collectively-developed goals. The following programs, unique to Network 2, empower staff in developing and furthering organizational objectives **(Fig. 1.11)**:

Fig 1.11



1.1a (4) One-VA: Senior leaders promote One VA collaborations with other agencies of the Department of Veterans Affairs including Veterans Benefits Administration and the National Cemetery System. Veterans benefits counselors have been placed at each medical center to assist veterans and their families with

issues related to VA benefits as well as burial and memorial affairs. Close collaboration among VA facilities and VBA has been achieved resulting in timely completion of compensation and pension examinations. Other examples of collaboration include the establishment of a multi-division Management Assistance Council, addressing issues which also involve veterans service organizations and other stakeholders. At the May 2000 Consensus Congress VA Best practices were shared nationwide, involving Veterans Benefits and the National Cemetery System. Examples include Goal Sharing, winning OPM's Pillar Award, the Quick Card patient satisfaction tool and the On-Demand staff and family education system.

1.1a.(5) One VA: As a result of One VA conferences as well as the VA Consensus Congress, our senior leaders have sought to provide seamless care to veterans patients through improved coordination and provision of services. For example, as a result of an intra-VA planning committee, involving VHA, VBA and NCS, a major project is being developed on the grounds of the Buffalo VAMC to house the Veterans Benefits Regional Office. Another example is the development of a one-stop inter-agency processing of base personnel at the Fort Drum Army base. This joint venture between VBA Regional Office, Department of Defense and Network 2 has improved compensation and pension exam processing while providing exit physicals for personnel. This has reduced time delays and improved convenience for the veteran.

1.1b(1) Organizational Performance Review: Performance measures, linked to key business drivers, are established to evaluate organizational effectiveness **(Fig 1.12)**. Network 2 relies on state of the art data generation tools to provide data and information for all major areas of organizational performance, i.e., Decision Support Objects **(Fig 1.5)** and Pulse Points. These data sources provide cumulative monthly updates and performance data for the past 3 fiscal years. Using the process described in **Fig 6.1,** senior leaders review this data monthly to assess organizational performance and progress, and to identify opportunities for improvement. Performance measure results are analyzed at the Network and Medical Center levels **(Fig 1.12)**. Trends in Network performance are identified and compared to rankings among all 22 Networks nationwide, the Best Practice Network and private sector benchmarks.

1.1b(2) Findings & Priorities for Improvement: Monthly analysis of key performance measure findings drive the establishment of action plans for areas of improvement. Discussion of results at ELC and TSPQ enable senior leaders to set priorities for improvement. Priorities are ranked based on patient needs and availability of resources. Competing priorities are ranked based on the degree of impact and value to patients. Performance improvement priorities are communicated to process champions for the development of solutions and associated action plans **(Fig 6.1)**. Success is evidenced by Network 2's superior performance as compared to 21 other VA networks, specifically as it relates to all 4 key business drivers **(Figs. 7.5A-B)**. Deployment of key business drivers and continuous data analysis enabled senior leaders to identify the above measures as priority elements requiring a dramatic turnaround in performance.

Fig 1.12

SENIOR LEADERS-PERFORMANCE MEASURE REVIEWS

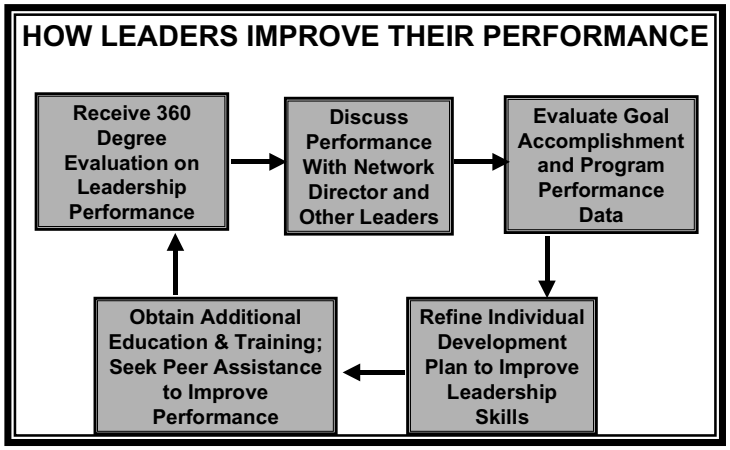
Key Business Drivers	Performance Measures	FY00 Recent Results	Ranking/Magnitude of Improvement	Reviewed By Whom
Patient Growth	•Number of Patients (Fig 7.5A) •% of New Patients (Fig 7.1C) •% Market Share (Fig 7.1A)	116,868 22.1% 17.2%	•2nd highest growth rate among 22 Networks •32,790 new patients were treated in FY00 •3rd highest market penetration rate among 22 Networks	Reviewed by ELC, TSPQ, LLC and marketing staff
Health Care Value	•Cost per Patient (Fig 7.2B) •Staffing per patient (Fig 7.2D) •Acute bed days of Care per 1000 Pts (Fig 7.2G)	$3,738 44.2 843.5	•3rd lowest cost among 22 Networks •Highest rate of reduction among 22 Networks '96-'00 •70.5% decrease from, '96-'00, 2nd highest reduction among 22 Networks	Reviewed by ELC, TSPQ, LLC
Customer Satisfaction	•Outpatient Satisfaction (Fig 7.1G-K) •Inpatient Satisfaction (Fig 7.1L-M) •Quick Card Results (Fig 7.1F)	70% 70% 95%	•70% rated care as excellent/good – VA best Practice •70% rated care as excellent/good – 2nd highest among 22 Networks •95% of patients rated their care as excellent/good	Reviewed by ELC, TSPQ, LLC, Customer Service Council, Employees
Excellence in Quality of Care	•Mental Health Follow-Up (Fig 7.5B) •Chronic Disease Index (Fig 7.5C) •Prevention Index (Fig 7.5E)	96% 91% 86%	•Best Practice among 22 Networks •Target score of 95% for FY01 •Target score of 90% for FY01 & 95% for FY02	Reviewed by ELC, LLC, Providers, Performance Management, Employees

1.1b(3) Results, Improvements, & Deployment: Performance indicators address each of the key business drivers and are deployed throughout the organization via monthly analysis of cost, workload and quality data. Results and priorities are made available to leaders and staff via Pulse Points, DSOs, employee newsletters, Town meetings, and the Network 2 Web page. Patients and stakeholders receive performance information via the Network Web page, the *Report to the Community*, Veterans Wellness Newsletter and through ELC and Management Advisory Council participation.

Recent results for key performance measures are presented in **Fig. 1.6, 1.12)**. Ongoing data analysis and deployment of results to all staff on CDI/PI performance identified learning opportunities and solutions to improve scores. Best practice solutions were communicated and deployed resulting in measurable improvements in the CDI/PI scores. **(Figs 7.5C-G).**

Future goals are described in **Fig 2.6&2.8, Cat 2.2a(1)** and include increasing patients served, establishing more Community Based Clinics, reducing waits and delays for outpatient care and continuing implementation of clinical guidelines.

1.1b(4) Improving Leadership Effectiveness: Our senior leaders continually seek opportunities to improve their effectiveness through daily communication with staff, examination of relevant performance measures and through the use of 360 degree evaluations. This permits the receipt of confidential numerical scores and verbal comments from a significant number of clinical and administrative customers, subordinates and peers **(Fig 1.13)**: Fig 1.13



Other improvement techniques include frequent meetings with staff, direct involvement in improvement activities, and better defining performance expectations to facilitate the redesign of processes **(Fig 6.1)**. Techniques selected by senior leaders are specifically chosen to improve performance by encouraging innovation and empowerment among staff and by applying lessons learned.. Notable areas of improved leadership effectiveness include clinic timeliness, and chronic disease and preventive index scores. Improvements in these areas have resulted from improved guidance, communication, and clear deployment of expectations from senior leaders **(Figs 7.5E, F &K)**. Staff feedback from Town Meetings and employee suggestion programs are used to assess leadership effectiveness. Front line staff have the opportunity to communicate to leadership staff via meetings with Medical Center Directors, Care Line Managers, e-mail messages and employee suggestion programs **(Cat 5.3c1,2&3)**. Senior leaders use this feedback to improve their leadership and communication skills and to develop Individual Development Plans. Examples of leadership improvement initiatives include membership and participation with the American Colleges of Health Care & Physician Executives. In addition, the High Performance Development Model is used to assess leader effectiveness via 5 core competencies **(Cat 5.1a(3))**..

1.2 Public Responsibility and Citizenship

1.2a(1) Societal Requirements: Network 2 provides healthcare to over 100,000 veterans across Upstate New York, provides numerous medical training opportunities, and serves as primary back-up to the Department of Defense for emergency preparedness. In maintaining numerous accreditations, Network 2 is inviting outside regulatory agencies to perform independent review of its healthcare practices. Network 2 is an agency of the U.S. Department of Veterans Affairs (DVA). As such, it operates under the rules and regulations promulgated by the DVA and other applicable federal law. Any claims for alleged torts, including medical malpractice, are handled pursuant to the provision of the Federal Tort Claims Act, 28 U.S.C. Section 2671, et seq. Network 2 has integrated its risk related programs as identified through the Patient Incident Reporting Program (PIR), Fact-finding/ Administrative Investigations, Medical Device Incident Reporting, Occurrence Screen Program

(OS) and Tort Claims. The Risk Management program supports a framework for activities including the Patient Advocate Program, Customer Satisfaction, Credentialing and Privileging, the National Practitioner Data Bank, Utilization Review, Infection Control, Safety and Health Program, Review of Rejected Applications and Informed Consent. **Fig 1.14** illustrates how Network 2 meets its responsibility to the public.

1.2.a.(2) Anticipating Public Concern: Network 2 maintains open communications with stakeholders through the Management Assistance Council (MAC), Congressional briefings, the Network 2 ELC, and local medical center consumer councils. This engenders open discussion, providing forums for identification of community concerns and obtaining pre-decisional input on planned initiatives. Network 2 operations. It has established a Statement of Organizational Ethics in recognition of the ethical responsibility that a health care organization has to the patients and community it serves. Network 2 has also published its policy and procedure defining the rights and responsibilities of patients. These rights and responsibilities are located in all patient care areas, patient handbooks, and patient information binders.

1.2b Support of Key Communities: In meeting its community responsibilities, Network 2 encourages and supports active employee participation in civic, educational, business, professional, health and service organizations. Involvement in key community and areas of emphasis are identified through the multiple feedback sources used in the strategic planning process and in setting organizational goals.

Fig 1.14

PUBLIC RESPONSIBILITY & CITIZENSHIP

SOCIAL	VISN 2 PRACTICE	MEASURE	TARGET
Maintain Quality Health Care	JCAHO Accreditation	Five of five medical centers hold 3-year JCAHO accreditations	Accreditation Score of ≥ 90
	NCQA Accreditation	Network-wide NCQA accreditation	2-Year Accreditation w/ commendation
	College of American Pathologists (CAP) Accreditation	Laboratory facilities to achieve CAP accreditation	Five of Five Labs are CAP Accredited
	CARF Accreditations	Behavioral Health and Rehabilitation Programs hold CARF accreditations	3 Behavioral Health programs and 1 Physical Rehab Medicine program are CARF Accredited
	Credentialing, Privileging, Reappraisal & Re-privileging Process	Licensed independent practitioners are subject to credentialing and privileging	All new hires credentialed & privileged; current practitioners re-credentialed and re-privileged every 2 years thereafter
Support Medical Education	Academic Affiliations	Medical centers maintain affiliations with medical schools and allied health organizations	Five of five medical centers maintain affiliations
	Resident & Allied Health Professional Training	Residents, health professionals trained	703 Residents, 1496 health professionals trained in FY00
Build Healthy Communities	Community Health Fairs	Participation in community-wide health fairs at all five medical centers	Over 100 Health Fairs Held at all Medical Centers during FY00
	Capital Asset Review (CARES)	Develop alternate uses for unused buildings-homeless veterans	Canandaigua and Batavia projects to create housing for low income and homeless veterans
	Network Emergency Preparedness Plan	Emergency Preparedness Plan serves the VA and the community	Annual emergency preparedness exercises & quarterly reviews of emergency preparedness initiatives

membership on various healthcare organizations such as the National Chronic Care Consortium and the Health Care Advisory Board assists Network 2 in predicting future needs. Network 2 employees maintain membership in numerous professional societies such as American College of Healthcare Executives, the American Medical Association, and American Psychologist Association as well.

1.2.a.(3) Ethical Practices: Network 2 has established and implemented a code of behavior for employees to provide a consistent, ethical framework for patient care and business

Network 2 has an active Speakers Bureau with professional staff going to schools, community organizations and other healthcare organizations to present on various healthcare issues of interest in their local communities. Network 2 employees serve on a number of community and charitable projects including the Combined Federal Campaign and the VA National Golden Age Games. Outreach efforts to the homeless in Network 2 is done in partnership with community organizations through Stand Downs. Another example is the Network 2 partnering with the Upstate New York Alzheimers Association to share technical expertise, educational resources and community support mechanisms, targeting support for veterans, non-veteran caregivers & their families.

2.0 STRATEGIC PLANNING

Strategic Planning permeates all aspects of our organization, assuring universal staff involvement and empowerment (Goal Sharing & Interactive Planning), while continually assessing and refining health care services. Thorough a customer-focused, staff driven process, we are able to meet rapidly changing needs and customer requirements.

2.1a(1) Strategic Planning Process: The Strategy Development process defines Network 2's immediate and future plans to provide high quality services to the veteran population. Network 2 has developed a foremost goal as follows **(Fig 2.1)**:

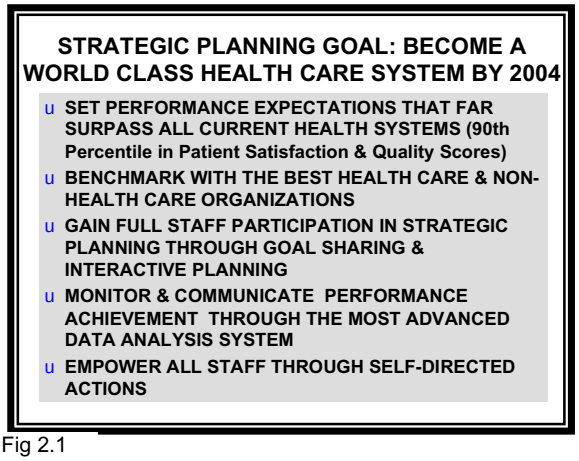


Fig 2.1

Crucial to the development of short and long range goals and objectives is the establishment of measurable performance targets for key determinants of organizational success **(Fig. 2.10)**. The strategic planning process incorporates information from patients including customer satisfaction surveys, and financial and performance data in the formulation of strategic objectives. This participative process involves all levels of the organization including front line as well as senior leadership in the formulation of goals and associated strategies. The process is illustrated in **Fig. 2.2**:

Network 2 applies an Interactive Planning Process through which staff at all levels of the organization participate in formulating the organization's future. As a vital component of the planning process, Care Lines and key program areas participate in a series of visioning exercises, through which a desired future is developed, along with corresponding strategies. Interactive Planning is based upon the concept that the more staff participating in the process, the greater the likelihood that plans will be successfully implemented through widespread ownership of outcomes **(Fig. 2.3)**:

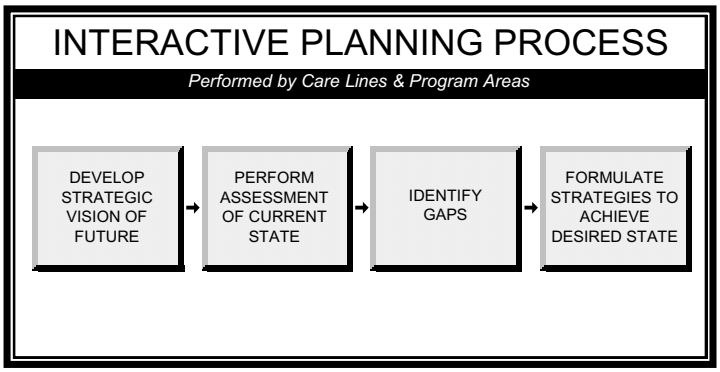


Fig 2.3

Care lines and key program areas develop strategic objectives in support of each of VHA's Six for 2006 Goals, including quantifiable performance measures to accurately gauge achievement. Network 2 has proactively established 2006 performance targets despite the fact that VA national targets are undeveloped and remain in the discussion stage **(Fig 2.11).**

Primary responsibility for strategic planning resides with the Network ELC which serves as the governing body for Network 2. Network planning staff are responsible for implementing the steps of the strategic planning process, for providing workload and financial data and for leading in the development of goals and objectives. Care Line

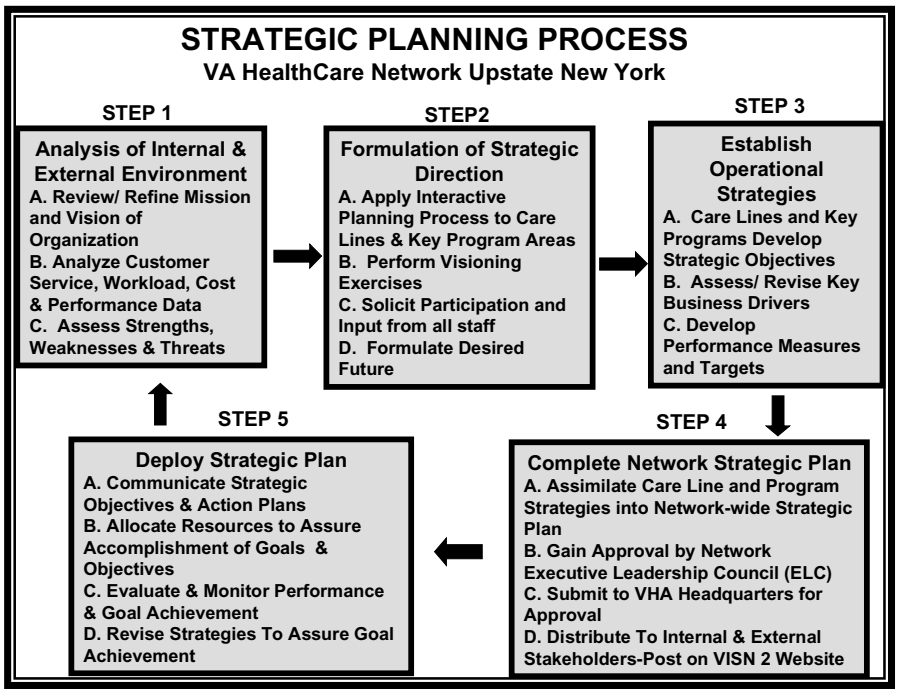


Fig 2.2

Managers and Medical Center Directors are responsible for broad solicitation of input from all levels of the organization, towards the formulation of operational strategies. Network 2 applies information from a wide array of stakeholder groups in the formulation of organizational goals and operational objectives **(Figs. 2.2 & 2.3)**. Forums include the ELC, composed of Network and Medical Center staff, veteran service organizations, union representatives and community leaders **(Fig 1.4)**. The Union Council and Management Assistance Council (MAC), composed of a wide array of network stakeholders, also provide valuable information toward the formulation of organizational policy. Meetings with veteran service organizations and congressional representatives are held throughout the year at respective medical center locations, with information incorporated at the local and network levels.

2.1a(2) Consideration of Key Factors:
The Network 2 Strategic Planning process incorporates a full range of information in determining strategic goals and operational objectives. Sources of information encompass key data related to cost, workload and productivity, customer feedback from all levels of the organization **(Figs 2.3&2.4, Cat 1.1a(3))**, analyses of the internal and external environment including financial risks and market competition. Planning input is broadly solicited from constituents through the Network 2 Website, Town Meetings and through forums with veteran organizations and congressional representatives **(Fig 1.4)**. Key Factors are described in **Fig. 2.4**.

Key Factors Considered in Strategic Planning

Key Factors	Strategy
Customer Needs and Expectations	♦ Applies information from a diverse stakeholder groups including: Customer Satisfaction Results, Veterans Service Organizations, Congressional delegations, Patient Advocates, Patient Complaint Data ♦ Network Customer Service Council led in the development of the Network Consult Response Time and Network Clinic Cancellation Policies. ♦ Network-Wide Implementation of the Quick Card, (recently recognized as a VA Best Practice). ♦ Creation of the Internal Shopper Program, Peer Consultation, Patient Pager and Greeter Programs.
Competitive Environment-Financial & Other Risks; New Technologies	♦ Network 2 evaluates its position relative to the health care environment ♦ Analyses of financial risk- potential budgetary losses and strategies to produce financial turnaround. ♦ Decisions to provide services in house or to contract - through evaluation of available community resources. ♦ Analyses conducted to determine Community Based Clinic "make vs. buy" decisions for each new site-considers capacity and quality of community providers, potential for partnerships with area providers, volume of potential patients served. ♦ Decision for a VA extended care facility to partner with a nearby community hospital
Human Resource Capabilities & Needs	♦ Employee needs are identified in accordance with Care Line programs and strategies. Assessments converted into numbers and types of staff with identified competency requirements. ♦ Annual employee evaluation performed to ensure a competent workforce with recruitment of needed staff ♦ An employee learning needs assessment conducted annually, utilized to identify skills training and related education required. ♦ VHA's High Performance Development Model aligned with VISN 2's strategic direction-to develop a highly skilled work force
Operational capabilities	♦ Applies best practices and lessons learned as a means to rapid organizational improvement ♦ All councils and teams encouraged to share most effective practices. ♦ Equipment/technology assessment annuall- prioritizes needs based current capability ♦ Chartered Strategic Information Council (SIC) to assess information system capability. ♦ VISN Research Advisory Council-evaluating, planning, and determining research priorities
Supplier & Partner Capabilities and Needs	♦ Strategic partnering and supplier agreements utilized to provide effective Network services ♦ Business Planning assesses and projects potential over the next 5 years. ♦ Expected capability with partners negotiated through written agreements. (Example-Prime Vendor Program developed with selected suppliers (see Process Management)

Fig 2.4

2.1b Key Strategic Objectives:
Strategic Objectives are developed by each Care Line and program area in accordance with VHA's Six for 2006 goals and four key business drivers, through the Interactive Planning Process described in **2.1a(1)**. Measurable targets in association with organizational goals are identified in **Figs 2.6, 2.10, 2.11)**. Customer service needs are fully incorporated into the development of strategic objectives, with new products and services created as a result of this process **(Figs 2.5, 3.2, 3.5)**.

Fig 2.5

Organizational results have been linked to each identified performance measure in **Fig. 1.12**.

Network 2 has developed strategic objectives and performance measures in support of VHA's Six for 2006 Goals (**Fig 2.11**). Key Business drivers have been aligned with Six for 2006 goals and strategic initiatives presented in **Fig. 2.6**.

2.2 Strategy Deployment
2.2a(1) Development of Action Plans: Network 2 Action Plans are established in accordance with the Care Line and Network strategic objectives and approved through the ELC. Timeframes for completion are developed to include responsible officials, status reports and dissemination of information.

Key Action Plans encompass plans for the continued transformation of the health delivery system, to achieve measurable improvements in quality and customer satisfaction, while continuing to expand veteran market penetration to 19% in 2001 and 21% by 2002. This will be accomplished by introducing initiatives to improve access to care and information, including new community based clinics, continued development of the Veteran Service Centers and the Knowledge Management office, and through enhanced clinic scheduling processes. Other action plans include participation with the Institute for Health care Improvement (IHI) Collaborative to reduce clinic waiting times **(Fig 7.5K)**, continued standardization of care through disease management programs and implementation of clinical guidelines, including improved compliance with chronic disease and preventive indices **(Fig7.5E &F)**. Network 2 has undergone integration of its patient data base among all facilities, to improve continuity of care and timely access to patient information from any location. Long range action plans encompass application of telemedicine at all sites consisting of universal computerization of medical

VHA'S SIX FOR 2006 GOALS & NETWORK 2 KEY BUSINESS DRIVERS

VHA's Six for 2006	Network 2 Key Business Driver(s)	Strategic Goals & Initiatives
I. Put Quality First Until First in Quality	1. Excellence in Quality	Measurable Improvements in Outcomes; NCQA 3 Year Accred.(Exceptional); Optimum Staff Development
II. Easy Access to Medical Knowledge, Expertise & Care	2. Outstanding Customer Service 3. Significant Patient Growth	30 day waits for specialty clinics; 20 minute appointment waits; Telemedicine, Telepsychiatry
III. Enhance, Preserve, and Restore Patient Function	4. Excellence in Quality 5. Outstanding Customer Service	Case Management for Diabetes, Dementia Care, Clinical Guidelines-Post Stroke Patients; Health Promotion-Frail Elderly
IV. Exceed Patients' Expectations	6. Outstanding Customer Service	Exceptional Inpatient & Outpatient Satisfaction, Clinic Upgrades, 48 hr. turnaround for Eyeglasses
V. Maximize Resource Use to Benefit Veterans	7. Optimum Health Care Value	Optimum Cost per patient (admin clinical, staffing); Maximize Alternate Revenue
VI. Build Healthy Communities	8. Excellence in Quality	Wellness Centers-All Sites Case Management-Al Sites; Exceptional Research, National Alzheimer's Project

Fig 2.6

records including computer imaging, and enhancements of physical plant to provide state of the art clinical facilities. Additional action plans include the continued integration of behavioral health and geriatric services within primary care clinics, development of two exam rooms per provider to expand accessibility and process improvements to achieve 48 hour turnaround time for eyeglasses. Short and long range action plans are presented in **Fig. 2.7**:

SELECTED SHORT & LONG TERM ACTION PLANS

Key Driver	Short Term Action Plans (2001-2002)	Long Term Action Plans (2003-2006)
Significant Patient Growth	♦ Open 6 Community Based Clinics ♦ Provide Direct Mailings To Veterans ♦ Perform Outreach To Minority Veterans	♦ Achieve Universal 20 min waiting times ♦ Provide 60 minute/60 mile access to specialties; 30 min/30 miles for Prim. Care
Optimum Health Care Value	♦ Control Drug Costs Through Provider Profiling ♦ Expand Home And Adult Day Health Care Alternatives to Institutionalization ♦ Apply Actuarial Data to Improve Utilization	♦ Develop advanced resource allocation processes to include risk factors ♦ Manage High Risk Populations ♦ Redesign Work-unit Key Processes
Outstanding Patient Satisfaction	♦ Participate In IHI Collaborative To Improve Waiting Times ♦ Achieve 48 Hour Turnaround for Eye Glasses ♦ Conduct Greeter & Internal Shopper Programs ♦ Provide Care & Bayer Training for Front-line	♦ Modernize Outpatient Clinics to Enhance Privacy and Patient Flow ♦ Develop Health Care Malls at all Sites ♦ Establish Excellent Patient Transportation System among Sites
Excellence in Quality	♦ Create Diabetic Management Program ♦ Apply Clinical Reminders for Performance Indicators ♦ Conduct Health Promotion for Frail Elderly ♦ Implement Case Management at each Site	♦ Develop Wellness Centers at all Sites ♦ Develop Full Electronic Medical Record ♦ Implement Clinical Imaging, Telemedicine/ Telepsychiatry at all sites

Fig 2.7

Network 2 applies private sector best practices in strategic planning in order to improve all facets of the process including resulting outcomes. Concerns over clinic timeliness led to the establishment of 20 minute standards, with reports presented monthly to the Network ELC (**Fig 2.10**). The achievement of one integrated database has further improved data accessibility and timeliness of patient care delivery.

2.2a(2&3) Human Resource Requirements:
Network 2, in partnership with labor unions, continues to align staff with programmatic objectives, with resources redirected to areas of greatest patient demand. Outpatient staffing enhancements, including Community Based Outpatient Clinics, home based and Adult Day Health Care Programs, will further improve veteran access to care and market share. Human Resource needs are determined based upon a workload driven financial model, through which care lines are funded in accordance with projected workload. This funding model applies a funding allotment per clinic stop, inpatient day or other appropriate workload unit across all patient care programs.

The number of unique patients projected for FY 2001 is the determinant that drives the FY 2001 financial model. Planned changes for FY 2001 are incorporated into the model, specific to patient care programs, in order to modify workload and resulting resource requirements. Care Line budgets are further subdivided by medical center in proportion to planned program requirements and projected workload. The FY 2001 Budget has been developed by Care Line in accordance with workload forecasts and related strategic initiatives. Human Resource objectives and resulting outcomes are presented in **Fig. 2.8**:

HUMAN RESOURCES ACTION PLAN

Goal	Approach	Results
Assure Optimum Staff Development	Provide Continuing Education & High Performance Development Model Training,	96% Continuing Education (Fig. 7.3D); 90% HPDM; (Fig. 7.3I)
Assure Full Participation in Strategic Planning	Implement Goal Sharing Program including development of work-unit goals.	100% Staff Participation(Fig. 7.3C)
Achieve Excellence in Employee Satisfaction	Administer Staff Satisfaction Surveys; Develop Employee Quick Cards in 2001	87% Personal Satisfaction from Job (Fig. 7.3H)
Minimize Staff Turnover	Achieve maximum staff retention by working with staff to provide for professional growth and improved job satisfaction	Clinical Staff Turnover (10.4%-Fig. 7.3E); RN (7.2%-Fig. 7.3F); MD (8.9%-Fig. 7.3G)
Create a Safe Work Environment	Provide training in work safety; light duty assignments	1.6 per 100 lost times claims rate in 2000 (Fig. 7.3J)
Reward & Recognize Staff	Reward staff in proportion to measurable contributions to organizational success.	$2.3 million in Performance Awards (Fig. 7.3A); $2.0 million Goal Sharing (Fig. 7.3B)
Achieve Excellent Management- Labor Relations	Include Labor Representation on all Network-wide Councils; Utilize Alternative Dispute Resolution	16 Unfair Labor Practices Filed in 2000 (Fig. 7.3K)

Fig 2.8

2.2.a(4) Key Performance Measures: Key performance measures have been established in accordance with VHA's Six for 2006 Strategic Goals **(Fig 2.6, 2.10)** and Network 2's Key Business Drivers **(Fig. 2.11).** Network 2 has proactively established performance measures and projections for **each of VHA's Six for 2006 Goals**, well ahead of VHA nationwide. Measures for one of the six goals (Quality) is shown in **(Fig. 2.10**). Progress is monitored through monthly analysis of cost, workload and quality performance data. Information is made available to Care Line Managers and Medical Center Directors and presented at both the Medical Center as well as the Network level. Monthly reports are provided to the ELC to assess performance, through which required action is directed in accordance with targeted goals and strategic objectives. Performance is made available to Network 2 stakeholders through ongoing posting of information on the Network 2 Web page. Network 2 continually compares its practices with national policies through heightened use of the VA internet, communication with veterans service organizations, as well as through close coordination with labor unions and academic affiliations. Network staff also serve on national committees, and are afforded the opportunity to provide input into national policies and programs.

2.2a(5) Communication & Deployment: Strategic objectives are posted on the Network 2 Website and also distributed widely to internal & external stakeholders including employees, veteran service organizations, congressional representatives, union partners, and University affiliates. **Figure 1.4** identifies the mechanisms used to publicize Network 2 Goals and objectives. Goal sharing programs have been established in concert with the deployment of the Network Strategic Plan, to assure universal employee involvement in the process. The intent is to go beyond mere knowledge of the strategic objectives by each employee, but rather to inculcate these principles through operational as well as financial incentives **(Fig 2.9)**. Network 2's success in achieving wide employee involvement is reflected in its exceptional successes related to access, cost reductions and customer service scores, results which are at or near the top for all 22 Networks **(Fig. 1.6)**. Network 2 monitors the achievement of organizational goals through monthly analysis of cost, workload and quality performance data. Information is made available to Care Line Managers and Medical Center Directors and presented at both the local as well as the Network level. Monthly reports are provided to the ELC to

Fig 2.9

PERFORMANCE MEASURES-QUALITY (SIX for 2006)

	ACTUAL				PROJECTIONS				
Measure	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2004	World Class 90th Percentile	FY 2006
Prevention Index	74%	80%	79%	86%	88%	90%	93%	93%	95%
Clinical Practice Guidelines (Chronic Disease)	79%	84%	85%	91%	92%	94%	95%	95%	97%
Mental Health Follow-Up	83%	96%	96%	96%- VA Best Practice	96.5%	97%	98%	98%	98%
Schizophrenia CPG - AIMS Completion Rate for Patients on Antipsychotic Medications	NA	NA	85%	93%	93%	93%	94%	94%	95%
% Sites Using Clinical Reminders for Performance Indicators	NA	NA	NA	NA	100%	100%	100%	100%	100%
NCQA Compliance	NA	NA	1 Year	2 year (Commendable)	2 year (Commendable)	3 year (Exceptional)	3 year (Exceptional)	3 year (Exceptional)	3 year (Exceptional)
High Performance Dev. Model % of Staff Trained	NA	NA	NA	75%	85%	95%	100%	100%	100%
Continuing Education-% of Staff Receiving 40 hours	NA	75%	86%	96%	97%	98%	99%	99%	100%

Fig 2.10

assess performance, through which required action is directed in accordance with targeted goals and strategic objectives. Performance data is made available to all Network 2 stakeholders through the deployment of mechanisms described in **Figure 1.4**. Network 2 has established a comprehensive system of data reporting including monthly Pulse Points and DSOs (**Fig 1.5**). This consists of monthly reporting of cost, quality and performance indicators with wide dissemination of data reports among all sites and Care Lines.

2.2b (1) Performance Projections: Performance projections have been established to achieve sustained excellence in all facets of organizational performance. Projections related to patient growth, cost, quality and customer satisfaction (Key Drivers) were deemed crucial for organizational success **(Fig 2.11)**

2.2b(2) Performance Projection Comparisons: Performance targets were established to position Network 2 in the highest bracket among VA facilities as well as among private sector health care systems. Network 2 is currently ranked in the top 3 out of 22 networks for 10 out of 11 measures identified in **Fig 2.11**.

We take a very wide view of the notion of benchmarking, exploring ideas of many leading organizations, including those outside of the health care industry. In fact we have applied some of the best ideas from non health care organizations including the Disney Corporation, and Ritz Carlton, implementing greeter programs, phantom shopper techniques, Quick Cards and Goal Sharing, much of which has brought positive acclaim to network 2. It must be noted that many of these progressive techniques, while receiving much subsequent praise, were initially looked upon with skepticism due to their innovative nature. This includes Goal Sharing, initially cited in potential conflict with VA regulations, and then receiving the OPM Pillar Award, as w ell as Disney training, initially questioned for its relevance to health care. These proactive approaches are testimony to Network 2's willingness to be on the cutting edge of innovative, customer and staff-focussed processes. Network 2's outstanding achievements **(Fig 1.6, 1.10)** coupled with its systematic plans to achieve world class status, reflect the effectiveness of these approaches. Network 2 is projected to rank 1st or 2nd by 2002 for all measures identified in **Fig. 2.11**, an unparalleled level of achievement. Network 2 benchmarks with the best organizations, both within and outside of health care, as illustrated throughout section 7. In accordance with the strategic planning process, projections for key performance measures have been established through 2006 **Fig. 2.11**. The approach to achieve world class status is based upon the principles of establishing the highest levels of performance, while empowering staff to take the necessary action to transform the organization. Achieving universal involvement in planning including the establishment of targets, will create the ownership of results required to achieve sustained levels of excellence.

PERFORMANCE PROJECTIONS FOR KEY MEASURES

		ACTUAL						PROJECTIONS				
Key Driver	Key Measure	1997	1998	1999	2000	VA BEST	Private Sector	2001	2002	2004	WORLD CLASS 90th Percentile	2006
Significant Patient Growth	% Market Penetration	12.60%	15.00%	16.40%	17.70%	20% (N18-Phoenix)	NA	19.00%	20.50%	22.00%	24.0%-Proj. VA Best	24.00%
	% Cat A Market Penetration	31.60%	34.80%	36.50%	37.50%	39.5% (N18-Phoenix)	NA	39.00%	41.00%	43.00%	45%-Proj VA Best	46.00%
Optimum Health Care Value	Cost per Patient	$4,883	$4,174	$4,071	$4,011	$3497 (N18-Phoenix)	$4853-AVG. US Health Plan Cost	$4,035	$4,019	$4,410	$4100-Proj. VA Best	$4,673
	Staffing per 1000 Patients	63.3	52.2	47.6	44.2	34.4 (N18-Phoenix)	NA	42.0	40.5	38.4	36 Proj. VA Best	35.5
Outstanding Customer Service	Patient Satisfaction -% Problems	21.00%	17.00%	15.60%	15.30%	14.84% (N1-Boston)	14.0%-Picker	14.00%	12.00%	9.00%	9.0%-Projected Picker	7.00%
	Pats. Rating Care VG or Exc.	64%	68%	70.00%	70.00%	71% (N1-Boston)	78% (90th % HEDIS)	72.00%	76.00%	80.00%	80%-Projected	85.00%
	Clinic Waiting Times-Primary Care											
	Days	NA	75	60	46.4 VA avg=57	19.4 (N19-Denver)	NA	30	28	25	25-Proj.	23
	% of Patients Seen in 20 Minutes	55%	60%	64%	64%	NA	NA	75%	85%	90%	90%-Proj.	92%
Excellence in Quality	Prevention Index	74.0%	80.0%	79.0%	86.0%	88% (N16-Jackson)	NA	88.0%	90.0%	95.0%	95% Proj	95.0%
	Chronic Disease Index	79.0%	84.0%	85.0%	91.0%	96% N19-Denver)	NA	92.0%	94.0%	95.0%	95% Proj	95.0%
	Mental Health Follow-Up	NA	96.0%	96.0%	96.0%	96% (N2-Albany)	70%-HEDIS (NCQA)	96.5%	97.0%	98.0%	98% Proj	98.0%

Fig 2.11

3.0 CUSTOMER FOCUS

3.1a(1) Customer & Market Knowledge: Network 2's customer is the patient. In order to understand the needs and expectations of our patients, Network 2 segments patients to tailor programs and services using the following criteria: geographic location, gender, age, Category A veterans, non-veterans, and special needs status (e.g. Spinal Cord Injury, Women Veterans, Post Traumatic Stress Disorder, Seriously Mentally Ill, Long Term Care) **(Fig 3.1)**. The Network's Marketing Team and senior leaders analyze this data for planning and development of actions. Feedback from patients, stakeholders and VSOs also provide valuable information to leaders in determining target segments and the specific health care needs of these segments. This information is incorporated into strategic planning **(Fig. 2.1)** and key process development **(Cat 6.1)**.

Network 2 Leaders assess demographic data to determine untapped market segments. Based on this analysis and in pursuit of patient growth, Network 2 develops plans to attract certain patient populations including women, and seriously mentally ill patients. Information obtained from surveys and marketing fairs resulted in the development of dedicated areas tailored to meet the special health care needs of women patients in a private and comfortable setting.

Network 2's main competitors are those health care organizations that provide services to insured veteran patients who choose not to use the VHA system. Network 2's marketing team uses geographic location, market penetration and usage patterns to develop action plans focused on capturing current non-users. **Fig 7.1A** illustrates market penetration. Network 2 has achieved best practice among 22 Networks for Access to Care since 1997. **(Fig 7.1G)** To further attract potential customers, marketing efforts incorporate key features, health care services and benefits of Network 2. New enrollees who are not actively using Network 2 for health care are surveyed and contacted.

3.1a(2&4) Listening & Learning: Knowledge of customer and market segments enables Network 2 to tailor listening and learning strategies to support marketing efforts, develop new programs, improve health care and increase satisfaction. Listening and learning techniques used to determine patient requirements and learn from their experiences include direct input, analysis of complaints and compliments, letters to the Network and Congress, stakeholder feedback and surveys **(Fig 3.2)**. Through the methods identified in Figure 3.2, Network 2 has determined several key patient programs: Veteran Service Centers (VSCs)**,** Vocational Rehab, Seriously Mentally Ill programs and Outpatient Community Based Clinics. Listening techniques routinely highlight Pharmacy Benefits as a key driver for patients in deciding to obtain care from Network 2.

Network 2 recognizes that listening and learning techniques must be re-evaluated to keep current with customer requirements. Through patient and stakeholder input, Network 2 identifies opportunities to enhance listening techniques to yield quicker/actionable feedback. Changes include development of Quick Cards for more immediate customer service feedback, addition of VSO, Union and veteran membership

Patient Groups & Market Segments

Segment	Reason for Segmenting	Knowledge Gained	How Used
Geographic Location	To assess market penetration	Identification of untapped markets or geographic locations	To promote patient growth in certain communities, i.e., Community Based Outpatient Clinics
Gender	Female patients needs differ from male patients	An understanding of the specific health care needs of male and female patients	To tailor programs and services to female & male patients, i.e., Women Health Centers
Diagnosis or Special Needs Status	Patients with certain diagnoses or special needs have unique service requirements than others	An understanding of the specific health care needs of special populations or Diagnoses	To tailor programs and services and track compliance with CPGs and CDI/PI, i.e., Seriously Mentally Ill Program
Age	Patients at certain ages require specific health care services	Identification of specific age cohorts for further studies and analysis	To tailor programs and services and track compliance with prevention guidelines, i.e., Preventive Care Screenings
Category A Veterans	To provide health care services to indigent veterans	Assessment of Category A market penetration and untapped areas	To promote growth in Category A Veterans, i.e., Focused marketing efforts to Category A Veterans
Non-veterans	Represent a source for alternative revenue	Information about third party coverage obtained	To enhance billing procedures and collections, i.e., Tri-Care

Figure 3.1

on ELC, establishment of a Network marketing team, and creation of the Virtual Help Desk and Web-page for internet based feedback

3.1a(3) Key Service Features: For current and former patients, Network 2 determines key health care service features and their importance to our patients using the techniques described in **Fig 3.3.** Surveys are mailed to non-users to assist leaders in understanding why veterans choose to use or not use Network 2 for health care services and are used in the planning process described in category **2.1**. It is also integrated in the design model described in category **6.1** for developing or enhancing services based on identified customer needs, health service feature expectations and key drivers for using Network 2 for healthcare services. Leaders incorporate market penetration and retention data into this process. The Network 2 Customer Service Council (CSC), chaired by a VP for Customer Service, integrates the Listening & Learning findings with the Network business plan. Data is aggregated and analyzed using various tools including trending analysis, comparisons, and cause and effect relationships. The CSC uses this input to formulate actions to improve health care and customer service. Network 2's Marketing Council incorporates the new or enhanced health care services/features into the Network wide marketing plan to attract and retain patients. Through this process, Network 2 has identified the following service features important to patients: Pharmacy Benefits, female oriented health care service environments, smoking cessation programs, timely access to services and appointments, and the Telcare Hotline for providing health care advice. Veterans Service Centers also aid patients in accessing VA healthcare and inquiring on eligibility, benefits and services. The CSC also publishes a semi-annual newsletter, "*Exceeding Expectations"* to share information and progress on customer service initiatives with staff, patients and stakeholders. A "Comping"/ Service recovery program has empowered staff to take required action, specifically at the front-line. **(Fig. 3.4)**

Listening & Learning Posts

LISTENING POSTS	LEARNING	APPLICATION OF LEARNING
Meetings with Veterans Service Officers *Current & Potential Pts*	**Information enables VISN to learn about user/potential user preferences, expectations and obtain feedback on newly initiated programs or future programmatic changes.**	**Development of Community Based Clinics**
Greeter Program *Current & Potential Pts*	**Staff serve as daily 'eyes & ears' regarding needs/expectations of patients and customers.**	**Improved Signage across at all Medical Centers**
Internal Shopper Program *Current & Potential Pts*	Team of surveyors evaluate features important to patients and customers (courtesy, cleanliness, safety, parking, handicapped accessibility, etc.)	Development of Travel Lounge
Network 2 Web-site *Current & Potential Pts*	**Direct user input is obtained on key requirements/needs.**	**Development of Virtual Help Desk**
Quickcards & Satisfaction Surveys *Current & Potential Pts*	Opportunity for patients/family members to give feedback on their perceptions of the care and services rendered.	Deployment of waits & delays performance standards
Patient Advocacy Program *Current & Potential Pts*	**Patient Representatives are highly visible and are a primary venue for obtaining complaints/input from veterans.**	**Development of Network Authorization Office**
VISN 2 marketing Team *Current & Potential Pts*	Direct user input is obtained on key requirements/needs.	Market to segments of veteran population, i.e. women, minorities
Questionnaires Surveys *Current & Potential Pts, Former Patients*	**Surveys designed to seek feedback from recent encounters and also to ask patients why they have left VA Healthcare.**	**Development of Veterans Service Center**

Figure 3.2

Key Customer Service Mechanisms

KEY ACCESS MECHANISMS	PURPOSE
Community Based Clinics, Primary & Specialty Care & Emergency Rooms	Provide easy and convenient access to health care services within the patient's local community. This is essential considering the large catchment area served by VISN 2. Specialty care is also available to all patients at all Medical Centers.
Tel-Care Program	Provides 24/7 Nurse triage services via a 1-800 easily accessed by patients
Veterans Service Centers	Provide "one stop shopping" & serve as a central point for assisting patients with questions regarding accessing VA healthcare, VA benefits, eligibility determination, billing questions, obtaining identification cards and general questions.
Patient Advocate Programs	Patient Advocates are highly visible and are a primary venue for patients/customers to obtain information, answers to questions and for reporting and resolving complaints.
VISN 2 Web-site/Virtual Help Desk	Internet technology and email communication which provides information to patients, customers and stakeholders on health programs & benefits and provides a forum for patients to seek and obtain answers to questions. Available 24/7.
Greeter Program	Patients/customers in need of assistance or information have immediate access to 'Greeters' upon entry into VISN 2 facilities. 'Greeters' are solution facilitators and good will diplomats.

Figure 3.3

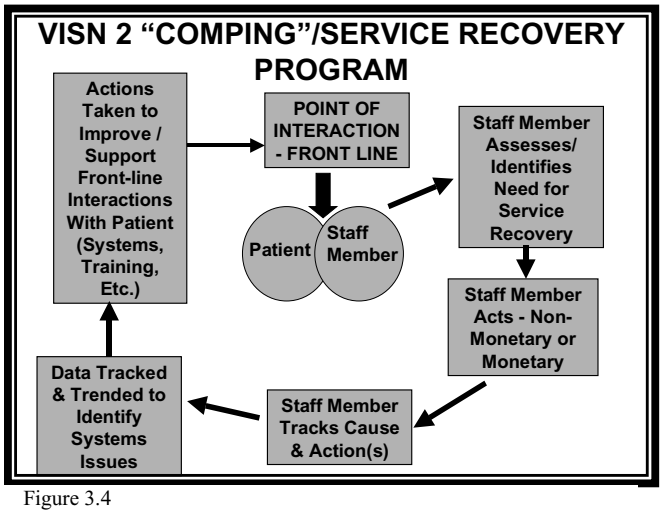


Figure 3.4

3.2a(1&2) Customer Satisfaction & Relationships: One component of satisfaction is the ability of patients to access services and information easily. Through the techniques described in **Fig 3.3**, Network 2 has identified key access mechanisms to facilitate the ability of patients to obtain health care, information or make complaints. Key mechanisms are listed in **Figs 3.3 & 6.5**. Customer service feedback is the leading mechanism for Network 2 to identify key contact requirements. The CSC reviews data collected from Network 2 patient advocacy programs, VA national satisfaction surveys/ Picker Institute, Quick Cards, Greeter Programs and marketing surveys. Trends and results are aggregated by individual question and are used to make improvements in service delivery and staff communication. Feedback obtained from patients identified the following contact expectations: prompt service, appropriate level of care, concern & courtesy shown by employees and completeness of explanations by staff. **Fig 5.5** identifies the training tools used to enhance staff communication skills based on these contact requirements. In addition to mandated training programs, Network 2 Leaders communicate customer service expectations through the adoption of customer service standards in performance evaluations for all employees. Leaders also communicate service expectations at Town Meetings, routine staff meetings and as part of the organization's Mission, Vision & Values statement. Network 2 continues to enhance and develop new contact avenues with patients, i.e., *Veterans' Wellness* newsletter, *Report to the Community* newsletter, Closed Circuit TV for patient viewing at the bedside, health touch kiosks and Virtual Help Desk.

3.2a(3) Complaint Management Process: The techniques described in **Fig 3.2** outline Network 2's methods for obtaining patient complaint information. Network leaders recognize and empower employees at the point of contact to resolve patient complaints at the lowest level. Front line staff receive specialized training **(Figs 5.5 & 5.6)** to enhance their skills in complaint resolution. If a staff member is unable to resolve the situation, he/she refers the patient to the Patient Advocate. The Patient Advocate program is integrated into the Network's Veteran Service Centers at each Medical Center. Patient Advocates are available to inpatients, outpatients, NHCU, Community Based Outpatient Clinics and Domiciliary patients. Patient Advocates document and track complaints, interventions and resolutions in a computerized database used for trending and analysis. The top areas of concern

Measurement of Customer Service

Measurement Method	Data Obtained	How Deployed
National Customer Satisfaction Survey	The National Customer Task Group used the Picker Institute findings to benchmark against 50 industry leaders in customer service – source for determining customer service performance against VHA national average and to Picker results in non-VA health care institutions. Results of customer service dimensions deemed most important to patients is presented in **Fig 7.1K**.	Reviewed by CSC, ELC & TSPQ to develop action plans. Results listed on DSOs & Pulse Points
National Customer Service and Timeliness Standards	Network 2 is an active participant in a national VA project to reduce waits and delays in our outpatient clinics. The project is done in partnership with the Institute for Health Care Improvement (IHI). The continuous testing of changes and the measurement of improvements in access, capacity, demand, efficiency and patient satisfaction have been instrumental in improving timely access to outpatient care in Network 2. **(Fig 7.5J)**	Data reviewed by CSC, ELC, TSPQ and available on DSOs and Pulse Points
Patient Advocate Database –	Database houses information relative to patient contacts/interventions and serves as a primary resource for evaluating patient dissatisfaction	Data is trended & reported ELC, CSC for development of actions.
Quick Card Program	Provides a *quick* avenue for obtaining instant feedback from patients. Corrective actions are immediately taken and are communicated to patients. **(Fig 7.1F)**	Data reviewed by CSC, TSPQ, ELC
Internal Shopper Program	Initiative designed to focus on the expectations of our customers as seen through the eyes of a VA employee. The implementation of a Patient Travel Lounge was inspired by VISN 2's Internal Shopper Program.	Information is used to take immediate corrective action.

Figure 3.5

include information/assistance, patient care, courtesy and timeliness. This information, along with data from quick cards, surveys, VSO, etc., is reviewed by the CSC and ELC using the tools identified in **3.1a(3)** to identify areas for improvement and develop associated action plans. Patient Advocates communicate regularly with patients until a satisfactory resolution is achieved.

Customer Service Activities

Comping/Service Recovery Program:
Training provided to staff on actions they can take to turn a negative event into a positive experience. Examples of recovery include: an apology, offering complimentary coffee or coupons for free beverages, offering an MCI card worth 10 minutes of long distance telephone service.
"Patient Pager":
Program used in variety of settings to facilitate the ability of patients to move freely about the Medical Center.
Exceeding Customer Expectations:
Newsletter produced semi-annually for staff and patients
Bayer Training for Providers:
See Fig. 5.5
CARE Training:
See Fig. 5.5
Patient Binder & Envelope:
Patient binders used on hospital inpatient units, at community -based clinics and at Veteran Service Centers to provide standard information on mission, vision, values and Patient Rights and responsibilities. Patient Envelopes are distributed to all enrolled VISN 2 veteran patients to provide both customer service and educational materials to assist them in interacting with the health care team.

Figure 3.6

Patients also have electronic options for reporting complaints, i.e., web-based quick card and Virtual Help Desk programs. Each help desk request is documented in an MS Access database to ensure follow up. The Network 2 website receives approximately 4000 hits per day. Quick Card complaints are acted upon immediately and communicated to the patient if contact information is provided. Quick Card and Virtual Help Desk results are aggregated and distributed to Network Leadership and CSC for analysis and exploration of opportunities for improvement.

Building Community Relationships

Marketing Activity	Examples
Fairs	Enrollment Fairs, Regional, County, NYS Health Fairs
Speakers Bureau	Professional staff presentations to schools, community support groups, professional groups, colleagues, VSO, VFWs
Reports/Newsletters	Veterans Wellness Newsletter, Report to the Community, VISN 2 comprehensive Healthcare Brochure mailed to all patients
Surveys/Contacts with Patients	Marketing survey targeted at non-users CBOC development 60 minutes/60 mile standard to top 5 specialties
Web-Page/Virtual Help Desk	Provides comprehensive listing of programs and services offered within VISN 2 and opportunities to seek answers to questions
Referral Linkages	Department of Labor offering of VA Healthcare to veterans without health care insurance

Figure 3.7

3.2a(4&5) Relationship Building: Network 2 has implemented many programs to foster and build positive relationships with our patients. Other programs in addition to the items mentioned in **Fig 3.2 & 3.3** are listed in **Fig 3.5**.

The Network Marketing Team in conjunction with the Care Lines and Network Public Affairs Group has launched aggressive outreach and enrollment strategies. The CSC and Marketing Team have shepherded specific actions via ELC approval to build and sustain healthy relationships **(Fig 3.4)**:

Through the local and Network CSCs, Network 2 re-evaluates approaches to ensuring easy access and relationship building to keep current with customer requirements and organizational direction. Patient/stakeholder expectations for more frequent information and integration of Internet communication have required Network 2 to refine its strategies. These changes include: implementation of a Wellness Newsletter, questionnaire to ascertain why veterans have left VA healthcare, veteran membership on ELC, development of the Virtual Help Desk and Web-page for internet based feedback, establishment of a Network marketing team, distribution of the *Annual Report to the Community* and development of press releases to promote VA research, technological advances and new medical services. Information obtained from these changes is used in the planning process described in category **2.1** and in the design model described in **6.1**. Our Virtual Help Desk has recently received a Scissors Award for making a significant difference in customer relations by enhancing communication with our patients.

3.2b(1) Customer Satisfaction: Network 2 is committed to providing excellent customer service. In 1996, the CSC was formed. The CSC continues to utilize various methods to measure patient satisfaction or dissatisfaction, and to identify opportunities for improvement with measurable actions. **(Fig 3.6)** Satisfied patients build repeat business and provide a valuable source for future referrals via word of mouth dialogue. Network 2 has been successful in improving satisfaction **(Figs 7.1F-M),** increasing patient retention **(Fig 7.1D)** and in patient growth **(Fig 7.5A)**.

Patient Satisfaction is also closely linked to health care outcomes. Network 2 uses surveys to improve the delivery of health care services by assessing patient expectations relative to health care outcomes. We have achieved best practice for customer satisfaction in Access to Care **(Fig 7.1G)** and Coordination of Care **(Fig 7.1I)**. Delivery of Preventive health care service and adherence to performance expectations is also a source for building loyalty and satisfaction with Network 2 services **(Fig 7.5D-G)**

Our Customer Service approach is based on improving access and quality by creating systems that listen, learn and improve. Feedback obtained from our various listening posts enable leaders and staff to understand service features that are important to patients. The collection of action-based information allows Network 2 to deploy prompt and effective solutions to patient complaints and needs as well as to enhance satisfaction and build patient and provider loyalty. Effective customer service ensures customer retention and positive referrals. **(Figs 3.2 & 7.1D)**

3.2b(2) Follow Up Communication: Mentioned in previous sections, the Quick Card, Internal Shopper, Patient Advocate, Comping and Greeter programs provide more immediate and actionable service recovery feedback on recently delivered services. This information is quickly converted into action items by local staff and leadership to improve service and health care delivery. Each Medical Center in Network 2 also performs telephone surveys within 48 hours of discharge from an inpatient stay. This survey evaluates the status of recently discharged patients and provides an opportunity for patients to clarify or get answers to questions. The patient is also given an opportunity to provide feedback on his/her hospitalization experience. This data is compiled on a quarterly basis for Network staff and leadership and is valuable in identifying areas for improvement. Feedback from this process resulted in:

- Development of business cards for house keeping staff so patients know whom to contact for these services.
- Pilot program to use similar cards on patient meal trays with a contact name & number in the dietary department for questions/answers.
- Development of a Patient Envelope to house patient education materials in a portable file.
- Development of an admissions video for patient education purposes.
- Development of a Patient Binder for general & Patient Rights/Responsibility information.

3.2b(3) Satisfaction Comparisons: An essential component of measuring customer satisfaction is an analysis of Network 2 performance relative to industry benchmarks and/or similar health care organizations. We actively participate in the VA National Customer Satisfaction Survey, which uses the Picker Institute findings to benchmark against 50 industry leaders in customer service. This survey is a primary source for measuring Network 2 customer service performance against other VA Networks and non-VA health care institutions. **(Fig 7.1G & Fig 7.1H)** Network 2 is an active participant in a national VA project to measure waits and delays. Timeliness is tracked and readily compared to other Networks.**(Fig 7.5J)**

3.2b(4) Keeping Approaches Current: The ELC and CSC are the key groups that evaluate how well the Network has learned from its patient experiences. The CSC recommends meaningful plans and actions based on patient experience feedback, strategic goals and tactical plans. The CSC is responsible for evaluating Network 2 performance and exploring VA and non-VA best practices. Through this process, we have adopted several "best practices" from local HMOs which assisted in the development of the Veterans Service Center and Patient Binder. Listening to our customers' feedback and understanding the nature and reasons for both positive and negative experiences assists the ELC and planners to develop strategic and operational actions. Analyses of measuring techniques are critical to becoming more responsive to our patients needs and in identifying new and creative ways to measure satisfaction. The CSC has developed many creative tools and programs to measure satisfaction since its inception in 1996, including the Greeter Program, Quick Cards, Patient Pager, Customer Service Newsletter, Internal Shopper Program, and Virtual Help Desk. Since national satisfaction data is reported annually, Network 2 developed the Quick Card Program to provide more frequent feedback. This program has been identified as a best practice and is currently being deployed in other Networks. In FY00, the CSC received the USH Innovations Award for their creativity and work to improve VA systems for our patients.

4.0 INFORMATION & ANALYSIS

4.1a(1) Network 2 selects measures on the basis of their relevance and value in evaluating achievement of organizational goals and objectives. We have developed a Network-wide set of performance measures that are linked to the key business drivers **(Fig 1.3)** so that we can evaluate the performance of key processes, outputs and results as they relate to planned clinical, financial and operational performance. Our senior leaders review this data monthly to assess their own and organizational performance, and identify opportunities for improvement **(Cat 1.1b(1))**. To improve overall organizational performance and patient outcomes, performance indicator results are incorporated into the strategic planning process described in category **2.1** and the health care service design/redesign process described in **Fig 6.1.** Our selected indicators are valuable tools in evaluating daily operations **(Fig 4.1)**. Each Care Line, department and unit also develops performance indicators aligned with Network 2's key business drivers. The Goalsharing Program is an integral part of our plan to monitor how we operationalize our strategic plans. Additionally, our department and unit level measures provide a systematic way to evaluate daily operations.

Integration & Completeness: Network 2 has deployed a superior data system to achieve universal access to information that enhances decision-making for our senior leaders as well as front line staff **(Figs 5.3 & 4.4).** Network 2 was the first Network to initiate a Network-wide database integration to achieve a single electronic healthcare record for every patient. Regardless of where the patient is receiving services in Network 2, the provider accesses the total patient record without delay. The Strategic Information Council is the means we use to consolidate our information systems, processes and resources under one "umbrella" **(Fig 4.2).**

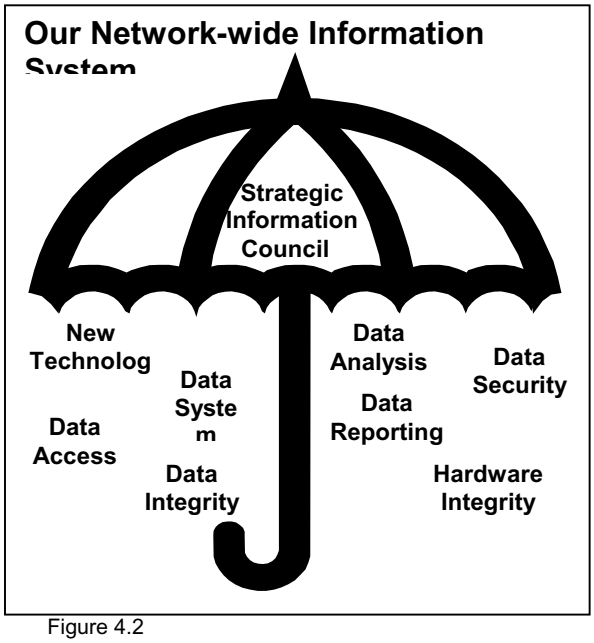


Figure 4.2

This infrastructure facilitates the rapid exchange of pertinent financial, operational and clinical information among our facilities and Care Lines, employing combinations of point and click computer utilities, easily accessible integrated computer systems and the VA Intranet. Key performance measure results are widely disseminated in written and verbal forms, analyzed and used to achieve rapid systems improvement, widespread staff involvement and individual ownership of results. Our Goalsharing Program and a standardized set of measures integrate and align

How We Use Indicators to Evaluate Daily Operations

Performance Measure & Key Business Drivers (KBD)	Linkage Results	Relationship to Strategy (Key Business Drivers)	Examples of Relevance to Daily Operations
Number of Patients	Fig 7.5C	PATIENT GROWTH	Used to determine appropriate staffing levels, resource needs, demand for services, marketing fairs, Untapped markets, establishment of Community Based Outpatient Clinics
% of New Patients	Fig 7.1C		
% Market Penetration	Fig 7.1A		
Cost Per Patient	Fig 7.2B	VALUE & EFFICIENCY	Evaluation of standardization efforts, use of blanket purchase agreements/group purchase discounts, evaluation of staffing levels, analysis of length of stay & associated discharge processes
Staffing Per Patient	Fig 7.2D		
Acute Bed Days of Care	Fig 7.2G		
Outpatient Satisfaction	Fig 7.1K	CUSTOMER SERVICE	Evaluation of customer service, timeliness of services, systematic changes to daily operations to improve customer satisfaction, development of programs to enhance health care service delivery
Inpatient Satisfaction	Fig 7.1M		
Quick Card Results	Fig 7.1E		
Mental Health Follow Up	Fig 7.5D	QUALITY HEALTHCARE	Standardized measures of quality are integrated into daily delivery of health care services via continuous provider education, enhanced documentation tools, and patient education
Chronic Disease Index	Fig 7.5E		
Preventive Index	Fig 7.5F		

organizational and individual performance expectations with key business drivers.

Complete data is the key foundation in our performance measure analyses. **Fig 4.3** illustrates how we select data criteria that ensure completeness. Network 2 equally weighs each of these factors when considering data.

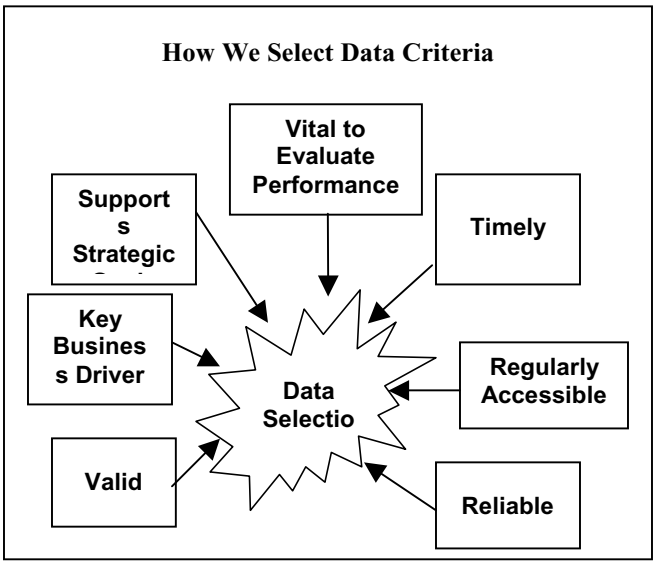


Figure 4.3

Comparative Data & Information: Network 2 leaders use comparative data to set stretch goals, evaluate performance and target areas for improvements **(Cat 3.2b(3))**. Comparative data and information is selected based on its potential for benchmarking, applicability to stretch goal formulation, level of compatibility with Network measures/data, potential benefit to patient care outcomes, and relevance to Network key business drivers and processes. Our success in using this technique is reflected in reduced cost per patient, increased patient growth and market penetration, improved customer satisfaction scores and enhanced quality of care **(Figs 7.2B, 7.1A&B, 7.1F-M, 7.5D-J).** Stretch goals were established based on comparisons to best practice levels in other Veterans Integrated Service Networks and projected goals were defined via the strategic planning process **(Cat 2.2b).**

Our leaders agree that comparing Network 2 performance measure results against the best practice Network, National/Network targets, the VHA average and when possible, non-VA industry standards, is effective in setting stretch goals and targeting improvements **(7.5A, B).** Among others, we use the Picker Institute patient satisfaction indicators to benchmark our satisfaction scores against fifty industry leaders in customer service.

Data Reliability & Confidentiality: We have assigned Information Security and Compliance Officers to maintain control of electronic system access and system integrity, reliability and optimization of equipment. The Strategic Information Council ensures that hardware and software meet end users' needs, are identified and implemented in an effective manner and are maintained to ensure reliability of systems **(Fig 4.2).** Leaders and staff incorporate statistically significant sample sizes into the performance review process to ensure valid results are obtained. Data and performance measure results are further broken down to analyze components of a process or outcome when needed. For example, Quick Card results are analyzed by individual question.

Network 2 established a Knowledge Management Office (KMO) to formalize the system of data generation and dissemination. Incorporating the VA Intranet, VA Austin databases and our integrated computer system, our KMO (a member of the Strategic Information Council)ensures that data maintained in Network 2 databases are accurate and complete.

Clinical & Financial Understanding of Improvement Options: Network 2 has identified a series of indicators to provide quantifiable information related to clinical, operational and financial performance **(Fig 6.5)**.

Through the application of data management systems, we focus on improving disease management, preventive health practices, timeliness of clinic treatments and external accreditations. Indicators address quality measures **(Figs 7.5D-J)**, customer service **(Figs 7.1E-M)**, employee development **(Figs 7.3A-D, I)** and access **(Figs 7.1A-C, 7.1G & 7.5C)**. Clinical improvement options are determined by quality indicator results. Past Chronic Disease Indicator / Preventive Index scores led to the development of a documentation tool and a systematic provider education plan which resulted in improved health care practices as evidenced by increased screening of patients in a primary care setting. Clinical improvements are also made in

concert with the development of new technologies. We continually invest in the purchase and upgrade of state-of-the-art diagnostic technologies to improve and refine the delivery of care. Advances in technology, age of the equipment, anticipated demand, amount of down-time and overall cost are considered in this process **(Cat 6.1a(4))**. We recently began performing a new procedure approved by the FDA called Endografts, an image-guided procedure for the repair of aortic abdominal aneurysm (AAA). This procedure is less intrusive and more cost effective than traditional open-heart surgery while offering quicker patient recovery time and shorter inpatient stays.

Network 2 uses cost per patient, total staffing per patient and acute bed days of care per 1,000 patients treated **(Figs 7.2B, D &G)** in analyzing and improving its organizational efficiency. Subsets of these measures, such as drug costs per patient, are also used in analyzing variances **(Figs 7.2F)** and have led to high-volume discounts and standardization of operations **(Fig 7.4D)**. Further, Network 2 initiated a Utilization Summit in FY2000, an innovative forum where clinical and administrative participants worked together to find opportunities to reduce drug costs without compromising the quality of care we deliver. Appropriate utilization of drugs and diagnostic studies were essential goals of the summit to achieve optimal patient care and improve Network efficiency. The evaluation of Proton Pump Inhibitor Usage was a major outcome of our Utilization Summit.

Correlations/Projections of Data to Support Planning: Network 2 applies a series of data projections in support of the strategic planning process. Projections include veteran population forecasts by age and gender, inpatients and outpatients treated, operating bed levels, and cost and funding resources. Projections are presented to our Executive Leadership Council in order to establish our strategic direction. The data are used by our Care Lines, key Network Councils and Medical Centers to develop strategies to achieve targeted goals and objectives. Projections are also made for key performance measures linked to key business drivers **(Cat 2.2b(1) & Fig 2.7)**. Forecasts and review of data enable our leaders to anticipate changes in health care delivery systems, resource availability, regulatory requirements, and patient and employee expectations. These changes are incorporated into the strategic planning process described in **Fig 2.2** and have been specifically used to transform Network 2 into an integrated healthcare Network focusing on ambulatory care.

4.1a(2) Keeping Performance Measurement Current: Network 2 updates data on key measures on a monthly or quarterly basis and compares performance with previous periods to assess current levels of achievement. Data is used to compare relative success of Network 2 against VA best practice and other Networks. Our databases are also updated monthly with nationwide data to ensure up-to-date, moving comparisons over time.

Our performance measures keep pace with the change from focusing on inpatient care to the delivery of care in the outpatient setting. Our standards reflect our current processes that ensure that patients have access to primary care within 60 minutes or 60 miles of their home, that no patient will wait more than 20 minutes for his or her appointment, and that a patient can get an appointment within 30 days of his or her request **(Fig 7.1E)**. Our Goalsharing Program also ensures unit performance measures are current and applicable **(Cat. 5.1a2)**.

Network 2's Decision Support Objects (DSOs) and Pulse Points represent the VA's most comprehensive Network-wide system for maintaining current performance data and has been showcased on a national level as a VA best practice.

We continue to use the Picker Institute's national comparative customer satisfaction scores for comparisons against industry leaders. Since

On-Demand Access to Data in Network 2

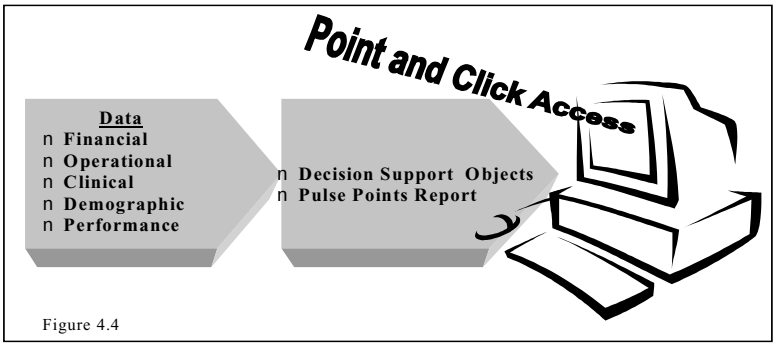


Figure 4.4

national feedback is provided once annually, we developed the Quick Card and Internal Shopper Programs to provide more immediate feedback with quick cycle recovery to improve customer service.

Results of performance measures are made available on a Network-wide basis via automated, point and click desktop computer tools. Our Pulse Point, Decision Support Objects, and the Network 2 Website exemplify our Network's success in making data available at all levels in our organization. Measures encompass all facets of customer service, financial performance, quality and access to care. Indicators are refined to better measure organizational performance through the analysis of collected data.

Network 2 maintains a Network Quality Manager Officer who coordinates the performance management functions throughout our Network, with similar positions at each of our Medical Centers. Root Cause Analysis is a corner stone of our performance management program. Risk Managers are intimately involved in this process and appoint a team of individuals to assess systems issues. This ensures that our processes
are appropriate, that we maintain a safe environment for patients and staff alike, and that we remain current with our patients' health care service needs and expectations.

4.2 Analysis of Organizational Performance

4.2a(1) Analysis of Data: Network 2 collects and aggregates data and displays it for analysis in Pulse Points and in Decision Support Objects. The Pulse Points report contains a monthly summary and analytical comments on organizational performance. Decision Support Objects are placed on our senior leader desktop computers providing results in a point and click format for key categories and measures. Pulse Points and Decision Support Objects provide data on all major indicators of our organizational performance. This enables our senior leaders to assess overall performance relative to strategic objectives and key business drivers **(Fig 4.4)**.
Data analysis is also done in support of the strategic planning process to anticipate future health care needs and process design/re-design as illustrated and discussed in category **6.1**.

An analysis of customer service results in prior years identified poor performance and an opportunity for improvement. In response, we took a series of planned steps to improve our customer service performance. These steps included the establishment of the Customer Service Council, focused training seminars **(Fig 5.6)**, development of the Quick Card Patient Feedback and Greeter Programs and adoption of customer service performance standards for all staff. The increase in customer satisfaction results demonstrates that the actions we took have effectively turned patient dissatisfaction into patient delight. **(Fig. 7.1E-M)**.

There are various methods that we use to analyze data including trending analysis, projections, comparisons, force-field analysis, pareto analysis, root cause analysis, and cause and effect relationships. The results are reviewed and acted upon by our senior leaders at the Executive Leadership Council, Local (Medical Center) Leadership Councils and key Network Councils. The analysis of data assists our leaders and managers in decision-making, resource allocations, operations improvement, health care outcomes improvement and in strategic planning. Our use of comparative data to similar organizations is a key element in defining stretch goals and driving innovations and improvements in our Network.

How We Use Data Analyses to Measure Our Success in Meeting Our Key Business Drivers

Key Business Driver	*Types of Analysis*
Patient Growth	• Market Penetration Changes • Increase in Number of Patients Treated • Outpatient Visit trends
Customer Service	• Trends in Waits & Delays for Appointments • National VA Patient Satisfaction Comparisons • Reported Complaint Trends
Health Care Value	• Cost per Patient Trends • Staff Turnover Rates • Resource Allocation Analysis
Quality Healthcare	• Performance of Preventive Care and Chronic Disease Screens, and Implementing Follow-up Treatment • Education and Training Trends • Outcome Monitors

Figure 4.5

4.2a(2) Analysis Linked to Work Group &/or Operations: In order for our Network and Care Line Managers to assess how our organization is performing in relation to key business drivers, goals and plans, a monthly review of data and results is done at all levels of the organization. Results and priorities are made available to all employees via Pulse Points, Decision Support Objects, employee newsletters, town meetings, and the Network 2 Web page. Based on the comparison of results to pre-established expectations, the Plan-Do-Study-Act (PDSA) approach is employed to stabilize, improve or facilitate always higher performance at the Network, Medical Center, department and unit levels **(Fig 6.1)**. Improvement plans are initiated based on analysis of generated results and the PDSA process **(Fig. 6.4).**

How We Support Our Daily Operations with Effective Communication of Data

Key Product or Process	*How data used to support Daily Operations*
Diagnosing, Treating & Preventing Diseases	Information on Clinical Practice Guidelines, CDI/PI scores and health care outcomes are used to adjust the delivery of care performed on a daily basis, i.e., referral of outpatients to our Smoking Cessation Program.
Customer Service	Trends in Waits & Delays, Satisfaction Results, reported complaints are used to take corrective action to daily operations, i.e., Clinic timeliness, Quick Cards
Enrolling Patients	Market Penetration Data, increase in patients treated are used to target recruitment and health fairs and for CBOC development

Figure 4.6

Our Goalsharing Program closely links unit and department goals and objectives with the strategic goals of Network 2. Each work unit team is responsible for defining measures linked to the key business drivers. Employee work unit teams are monetarily awarded at the conclusion of the fiscal year if reported results match or exceed stated goals. This program continues to create a win-win platform for our organization, our employees and our patients **(Cat 5.1a3&4)**.

Network 2 conducts a comprehensive review and evaluation of results at the end of each fiscal year. In addition to utilizing feedback from prior Baldridge-Based award applications, we utilize prospective assessments of demographics, budget, and other environmental factors to current and future organizational capabilities. Monthly analysis of results by our leadership, staff and Network Councils support our dynamic strategic planning process, allowing for timely course corrections throughout the year and concurrent, effective decision making based on meaningful and relevant data.

Network 2 ranks high against other Networks for a series of key measures related to customer service, quality and cost-effectiveness. A consistent level of achievement has been maintained across all measures as evidenced by aggregate scores at the top among all Networks. **(Figs 7.5A, B)**

4.2a(3) Analysis supports Daily Operations: Our continuous data retrieval and analysis is aimed at assessing health care processes to facilitate achievement of performance targets for key business drivers. Review of key data by leaders, supervisors, unit employees and Network Councils contribute to organizational learning and an understanding of organizational performance. This facilitates the development of needed action plans to improve health care and the processes that support health care delivery on a daily basis. **Figs 4.5 & 4.6** provide examples of analyses performed in Network 2 and how we used them in our daily operations. The ongoing analysis of data on waits and delays in our outpatient clinics and the continuous testing of action plans in the areas of access, capacity, demand, efficiency and patient satisfaction were effectively applied to dramatically improve timely access to outpatient care. The process owners (staff) identified systematic changes to daily operations, such as scheduling processes, and innovative solutions to clinic management to achieve overall improvements **(Fig 7.5K).** Our leaders at each medical center also meet each morning to review pertinent daily information, such as hospital admissions and discharges, sentinel events, and service and patient care issues. This facilitates timely course corrections to ensure optimal daily performance.

5 HUMAN RESOURCE FOCUS

5.1 Work Systems: The Network 2 care line structure is designed to embrace and employ the talents and abilities of its employees as we define and continuously improve our processes. Based on Network-wide decisions that reflect the integration of the various needs of our patients' clinical and business needs, our structure aligns resources and accountability with the key health services delivery and support processes so that education and training are readily available. Coupled with mentoring, career development resources and clear performance requirements, every employee in Network 2 participates in defining the work systems needed to accomplish our strategic goals. The Human Resources Action Plan illustrated in **Figure 2.8** underscores our commitment to aligning individual with organizational goals.

5.1.a.(1&2) Work Design and Motivation: The Network 2 work systems facilitate the transition from hospital-based care of veterans to a collaborative Network-wide healthcare system by stressing interdisciplinary therapy, and coordinating and managing the infrastructure and processes necessary to support patients. We empower self-directed teams at both the Network and local levels. Our leaders at the Network, local and front line level have the authority and responsibility to design, organize and manage their work systems. This encourages staff involvement in the improvement and enhancement of work design down to our front line level. Our managers and supervisors are active members or sponsors of the teams and ensure that members are allowed appropriate respite from job duties so that their participation is maximized and timelines are met. We celebrate both successes and noble failures. Our teams are given broad direction or charters, enabling them to be innovative and creative in their analysis and recommendations. Teams can be formal, informal, temporary or long-term.
Figure 5.1 illustrates how our teams/councils have helped ensure continuing work design and redesign to maintain quality healthcare services.

5.1.a. (3&4) Performance Management and Recognition: Network 2 is the first Network in the Veterans Health Administration to implement a Network-wide Goalsharing Program; it is the means to achieve the broader defined Network 2 goals. We reward our employees for their contribution to the successful achievement of our strategic objectives, which are linked to our key business drivers **(Fig 7.3B)**. The Goalsharing Program is built on a team concept, with team objectives being defined by our teams. The commitment of our employees to achieving organizational goals is illustrated by the fact that

How Our Teams and Councils Design Work Systems

Mechanism	Project Example	Key Process/Support Process	Outcome/Impact
GHQ Team (temporary, formal)	Implement mental health for patients in primary care clinics using the General Health Questionnaire (GHQ)	Key Process: Diagnosis of Diseases and Conditions	All veterans seen in primary care settings are screened annually using the GHQ.
BCMA Implementation Team (temporary, formal)	Facilitate implementation of Bar Code Medicine Administration (BCMA) across Network 2	Key Process: Treatment of Diseases and Conditions	BCMA was fully implemented across the Network during 2000
Diabetes Project Team (short term, formal)	Design a disease management program for diabetes that would meet NCQA requirements	Key Process: Disease Prevention, Health Promotion and Health Status	Pilot study at Rochester Outpatient Clinic completed in 2000; clinical practices being implemented at other sites
Service Center Design Team (short term, informal)	Design an integrated customer service support system that would meet NCQA requirements	Key Process: Enrolling Patients	Establishment of Veteran Service Centers at all medical centers
Electronic Medical Records Committee (long-term, formal)	Migrate to a fully electronic medical record	Support Process: Management of Information	All orders are electronically entered into the medical record; progress notes are electronically entered into the medical record
Network Education Council (long-term, formal)	Improve the process for identifying and meeting education needs in the care lines	Support Process: Education and Development of Staff	NEC distributed education funds to each care line and assigned education coaches to help care lines define education plans
Capital Asset Team (long-term, formal)	Prioritize capital improvement needs	Support Process: Environment and Facilities Management	The first Network-wide capital assets plan based on care line input published in 2000
Fiscal Reengineering Task Group (temporary, informal)	Reengineer Network 2 Fiscal Service to better meet the needs of the care lines	Support Process: Financial Planning	Fiscal Services reengineered, fiscal coaches established for each care line; accounting and auditing functions consolidated

Figure 5.1

the Goalsharing Program was created by a Network-wide team comprised of labor and management representatives. A rousing success in its first year, our labor/management team used employee feedback to further refine and enhance the Goalsharing Program in its second year. As a result, our teams developed goals that were more meaningful to smaller, natural work groups and further reinforced the link to our key business drivers **(Fig 5.2)**. This increased our employee participation over previous years, especially at the front line level **(Fig 7.3C).** Now in its third year, our Goalsharing Program has been so successful in helping us meet our goals and objectives that additional monies have been made available to support further initiatives.

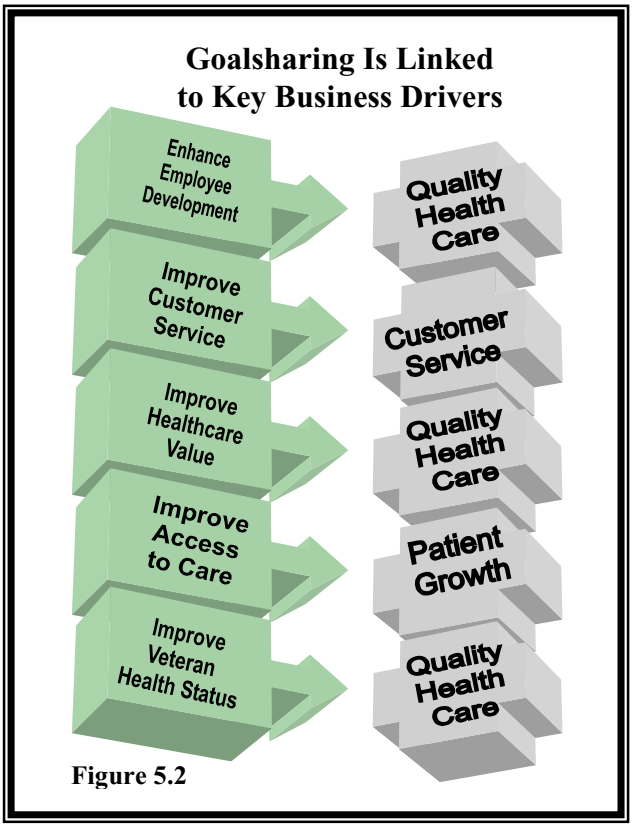


Figure 5.2

In August 2000, our Goalsharing Program received the Pillar Award, which is given by the U.S. Office of Personnel Management. It recognizes an exemplary employee performance practice that demonstrates how performance management supports the accomplishment of organizational goals and contributes to the organization's overall performance. While the independent agency recognition of this innovative program further strengthened our resolve to expand this program, the excitement evident in any discussion with front line staff on the program is an even greater testament to its success.

Network 2 also maintains an employee recognition and award program to celebrate, recognize and encourage efforts that constitute a special effort or act that is linked to the mission and exceeds that which is considered normal duties. Individuals and teams are eligible for awards and any employee can make an award nomination **(Fig 7.3A).**

5.1.a.(5) Effective Communication: The Network 2 data system gives universal information access which enhances our decision making and facilitates our processes **(Fig 5.3)**.

Effective communication is necessary within and across all levels of our Network in order to make the care, service and administration seamless and the achievement of objectives attainable. We employ numerous communication media including employee newsletters, electronic mail, customer service newsletters and teleconferencing. Our Network 2 web site provides fast, comprehensive access to employee information and resources. Our Business Plan, WebTop patient database, Employee Suggestion Form, Expert Referral Guide, and online Memoranda exemplify our strategy of cultivating an empowered workforce through open information access. Point and click access to information provides feedback loops to management and the rest of our organization, in addition to town meetings, staff meetings, and the local and Network Union Council meetings.

State of the Art Telecommunication Linkages
Placement of key VISN decisional and clinical / administrative management information on the desktop of leaders and managers: Decision Support Objects
Installation of an integrated Wide Area Network (WAN) that permits voice, data and video transmissions between and among all sites to support teleconferencing and telemedicine
Deployment of MS Exchange, a high performance, multi-format e-mail system, to all executives, managers and key clinical staff
VISN 2 Web Page, Pulse Points Performance Measures Report
Placement of over 5,000 personal computers across the VISN

Figure 5.3

Best practices are shared through Network-wide learning conferences where our employees gather to showcase and share their process improvements **(Fig 5.4).**
The implementation of process improvements is facilitated through our Transforming Systems Performance and Quality Council.

Coordinated Sharing of Process Improvements Through the Transforming Systems Performance and Quality Council			
How	**Who**	**What**	**Why**
Utilization Summit	Interdisciplin-ary teams share innovations	Network 2 achieves lower drug costs (Fig 7.?)	Key Business Driver: Optimizes Health Care Value
Education Summit	Education liaisons and care line representatives share practices and needs	Network 2 crafted a strategic education plan	Key Business Driver: Excellence in Quality
Institute for Health Care Improvement Collabora-tive	Cross-care line teams share successes and noble failures	Network 2 improved clinic wait times (Fig 7.?)	Key Business Driver: Significant Patient Growth

Figure 5.4

5.1.a.(6) Employee Characteristics: Position descriptions in Network 2 identify core competencies that form part of the vital knowledge and skills that are critical for our employees to perform proficiently. These core competencies are the foundation for all jobs and are factored into our training and development programs. Performance Based Interviewing (PBI) ensures that critical job elements pertaining to a specific job assignment can be met by the potential candidate before a selection is made.

Our practitioners are credentialed (a systematic process of screening and evaluating qualifications) and privileged (permitted to practice based on verification of clinical competence), meeting the requirements of JCAHO, NCQA and VHA policies and regulations. Practitioners include all licensed independent practitioners permitted by law and defined by medical staff bylaws to provide direct patient care. Policies and procedures related to the reduction and revocation of clinical privileges also apply to these individuals.

The Network 2 Affirmative Employment Program defines our policy for developing, implementing, monitoring and evaluating our annual Affirmative Employment Program Plan and Reports of accomplishments. It requires that sufficient resources are allocated to achieve the established goals of the program and the Federal Equal Opportunity Recruitment Program.

5.2 Staff Education, Training, and Development

5.2.a.(1,2&3) Training and Education Design: Our Network Education Council (NEC) provides oversight for our education program. The NEC consists of a cross section of employees and educators, management and support services. Responsibilities include oversight, guidance, coordination and overall development and implementation of our educational programs. To ensure that programs are aligned with the needs of the organization, our NEC evaluates the annual educational needs assessment from each care line, provides budgetary support and recommends distribution of education funds on a Network-wide basis. We align our plans with our strategic goals and key business drivers. The percentage of our employees who received continuing education was 96% in 2000 **(Fig 7.3D)**. **Fig 5.5** illustrates how we identify and manage our long- and short-term education needs for licensure, re-credentialing, development and career progression.

We employ an Individual Development Plan (IDP) to identify learning needs, as well as evaluate the effectiveness of training received. This cyclical process requires the employee and supervisor to collaboratively identify knowledge, skills and abilities that are needed to be successful; an IDP is reviewed and updated yearly or as needed. **Fig 5.6** illustrates the alignment of Network 2 education/training initiatives with the Key Business Driver Customer Satisfaction **(Cat 3.2a(2))**. The success of the training is reflected in the improved customer satisfaction scores from 1997 through 2000 **(Figs 7.1F-M)**.

Training Initiatives to Improve Customer Satisfaction		
Education/ Training Initiative	**Description**	**Target Group**
Extraordinary Service	Behavioral skills based program	All employees
Keeping the Skills Alive	Strengthen the skills of customer service trainers	Customer service trainers at each medical center
Bayer Training	Enrich customer service and communications during patient encounters	Providers
CARE Training	Better understand contact requirements and enhance communications skills	Front line staff

Figure 5.6

5.2.a.(4) Training Evaluation
The methods used to offer education and training to employees at all levels are illustrated in **Fig 5.7**.

We conduct post training evaluations to determine training participant satisfaction, applicability to the job and how future training can be improved. The effectiveness of the training is determined by performance and behavioral changes in our employees, which can be linked back to the individual's development plan or to a team's future performance outcome.

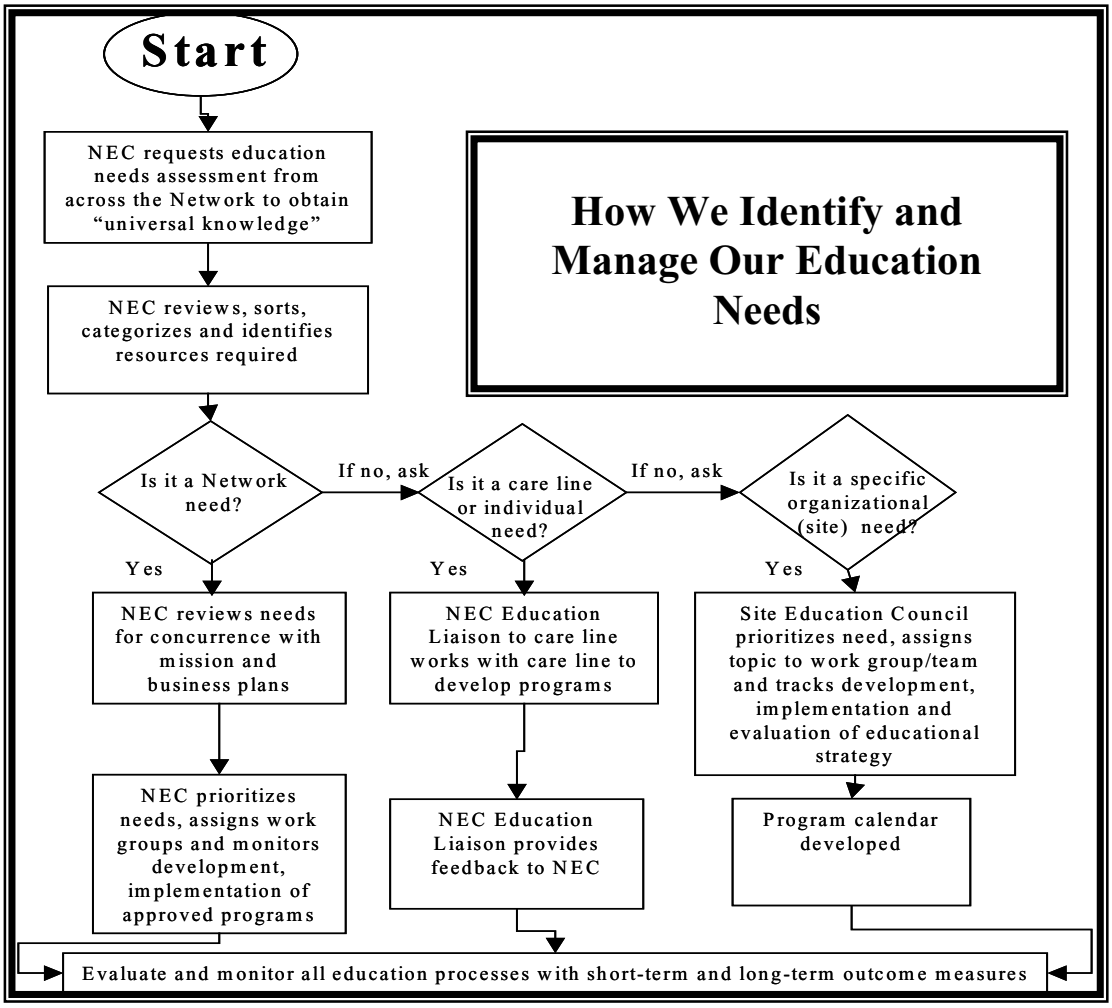


Figure 5.5

Widespread Training Opportunities

Key Process/ Support Process	Training	How Delivered
Enrolling Patients	Customer Service	Lecture, coaching/mentoring, learning maps, worksite learning initiatives
Diagnosing Patients	Diagnostic equipment (e.g., MRI)	Purchased training from original equipment manufacturer
Treating Patients	Clinical treatment procedures	Live lecture, developmental assignments, training through professional organizations, satellite programs
Health Promotion	Smoking Cessation	Purchased training, VISN 2 trainers
Management of Information	Computer Literacy	Computer-based, self-learning, developmental assignments, worksite learning initiatives, in-house training program
Education and Development	High Performance Development Model (Figure 7.3I)	Web-based, live lecture, learning maps, coaching and mentoring, staff meetings, videotapes
Environment and Facilities Management	Safety	In-house training, training through professional organizations, self learning, satellite programs
Financial Planning	Funding sources	Live lecture, staff meetings, learning maps

Figure 5.7

5.2.a.(5) Key Development, Training Needs: Network 2 embraces the High Performance Development Model (HPDM), a conceptual model for creating a learning organization focused on employee development. Introduced in 1999, 90.3% of our employees have been oriented to the model **(Fig 7.3I)**. The five components of the HPDM are (1) Core Competencies, (2) Continuous Learning / Assessment; (3) Performance Based Interviewing; (4) Coaching and Mentoring; and, (5) Performance Management. The eight Core Competencies are interpersonal effectiveness, customer service, systems thinking, flexibility / adaptability, creative thinking, organizational stewardship, personal mastery and technical skills.

Our HPDM Steering Committee has been appointed by our Executive Leadership Council, and we are committed to providing all employees within our Network the opportunity to learn about HPDM. An awareness and understanding of the

Core Competencies and how they relate to their individual jobs and performance is provided to all of our employees. We communicate the model through training sessions, meetings, pamphlets and brochures, the Network 2 web site and strategically placed posters in our work areas.

We use facilitated learning modules that include a tape of the core competencies, and do a post-test to ensure that we have achieved understanding of the concepts. Another interactive tool that we use is a Learning Map that helps our employees understand how their improvement in the core competencies benefits them and the organization.

Orientation is designed to convey values and familiarize our new employees with our work systems and processes. We provide an organizational orientation to every employee upon entry to service. A work unit orientation is provided on the care unit or job site. For training that is required annually we provide training/ reviews systematically for universal topics such as infection control, fire safety, computer security, ethical conduct, sexual harassment in the workplace, Equal Employment Opportunity, diversity and disaster preparedness. Each training episode is tracked via our Network-wide automated system called "TEMPO" to ensure training requirements are credited and mandatory training is met. TEMPO coordinators are assigned to document, track, and report education for employees, and information is submitted to senior leaders on a monthly basis.

5.2.a.(6) Performance Excellence: Continuous Quality Improvement (CQI) training is done Network-wide, and includes the use of such tools as process mapping, root cause analysis, data collection and display methods, force field analysis, and pareto analysis. In 2000, 100% of our employees received at least 40 hours of continuing education **(Fig 7.3D).** Because all employees participating in our Goalsharing Program in 2000, they received training in how to apply their CQI tools to define the measures that would demonstrate their success in meeting their goals. In addition, we created the Data Analyst Training Program in 1999 to train a corp of resources to assist our care line, Network and local leadership in improving quality control methods, analyzing performance and establishing benchmarks.

5.2.a.(7) Reinforcing Knowledge and Skills: Skill sets are identified in position descriptions. Competencies are interfaced and evaluated within individual development plans to emphasize key skills. Knowledge and skills are then reinforced through required training, competency reviews and annual performance evaluations. Attendance at external conferences and classes is approved based on linkage to key business drivers, the educational plan and our organizational needs.

Training for our health care providers include enhancing their discipline knowledge and skills, helping them to adjust to changes in health care delivery and delivery environments, and developing and utilizing clinical guidelines. Attendance at internal professional forums, such as grand rounds, are opportunities for case presentation and learning for our clinical staff.

5.3 Employee Well-Being and Satisfaction

5.3.a Work Environment: A Network-wide Safety and Health Program ensures a safe and healthful environment for our patients, visitors and employees, while effectively managing the costs of accidents and hazard prevention and complying with the Office of Safety and Health Administration (OSHA) regulations. The 75.4% reduction in lost times claims rate from 1996 to 2000 **(Fig 7.3J)** attests to the effectiveness of our safety and security program and employee training. Local safety committees consist of administrators, clinicians, safety staff and other employee representatives who identify program priorities and high risk areas. Additionally, local educational programs address safety practices and work area hazards. Employee representatives are considered crucial to the safety process, and are given authorized time away from their job duties to participate in Network safety and health activities, including training.

5.3.b.(1) Employee Support Climate: To foster an environment that is supportive of the needs of their employees, Network 2 Leadership utilizes various tactics of which involve employee participation and feedback. Published policies in support of this include the Statement of Organizational Ethics and Network 2 Management Code. Initiatives we have implemented include:

- Local policies that address work climate

- Alternate Dispute Resolution (ADR), a means to more quickly resolve differences between employees without resorting to a formal grievance process
- Union Partnership Council where labor and management work collaboratively to improve work conditions, awards programs, Goalsharing, training and strategic planning.
- Employee Assistance Program (EAP) available to all employees
- Employee health and wellness programs at each medical center; e.g., the QuitSmart® Smoking Cessation Program is free to all of our employees
- Benefits package allows for flex time schedules, and an option for time off in lieu of overtime pay
- Free computer literacy training

5.3.b.(2) Work Force Diversity: In Network 2 there is special emphasis on, but not limited to, raising the awareness of cultural observances from the community. We do this by bringing cultural events into the medical centers, participating in activities that support the President's initiative for black and Hispanic colleges and universities, and managing special emphasis programs for minorities, women, people with disabilities, and an African American scholarship program.

5.3.c.(1,2&3) Employee Satisfaction: Network 2 solicits feedback from its employees in various informal and formal forums. The direct participation of labor representatives on the Executive Leadership Council affords our leadership an excellent opportunity to understand and act on the concerns and needs that affect our staff throughout the Network. In addition, our Union Council fosters and maintains a cooperative, constructive labor-management relationship in the achievement of common goals and the improvement of our services to veterans in Upstate New York. Examples of the success of these collaborative efforts include:

- Improved strategic planning process
- Pre-decisional input to all Network-wide policies and procedures
- Goalsharing Program **(Figs 7.3B, 7.3C)**
- Redesign of the incentive awards program **(Fig 7.3A)**
- Labor Management Council Retreat in January 2000 which focused on the promotion of relationship building, reiterated interest-based bargaining techniques as a tool for partnership, and assisted in generating a shared vision for success

Town Meetings hosted by both Medical Center Directors and Care Line Directors on all shifts have provided informal settings for the frank and constructive exchange of dialogue between our employees and top leadership.

Assessment of employee satisfaction is also done through review of key measures, such as Clinical Staff Turnover Rates **(Fig 7.3E)**, Registered Nurse Turnover Rates **(Fig 7.3F)**, Physician Turnover Rates **(Fig 7.3G)**. and the number of Unfair Labor Practice claims made **(Fig 7.3K)**. An employee satisfaction survey has been done at one Network site in 2000 **(Fig 7.3H)** and at all sites in 2001. Also in 2001, the Employee Quick Card feedback process will be put in place across our Network. This feedback process mirrors the Customer Quick Card Process **(Fig 7.1E)** that has proven to be successful in helping us achieve dramatic customer satisfaction improvements.

6. Process Management

6.1 Health Care Service Processes

6.1a(1) Design Process: Network 2 requires processes that perform reliably, produce quality outcomes and meet customer needs and expectations. **Fig 6.1** illustrates how we design our processes. Our design process, which illustrates the Plan-Do-Study-Act cycle, guides our decisions on launching new or modified health care services. **Fig 6.4** illustrates how we used the principle requirements at each step of the design/redesign process to enroll more patients (key business driver) by expanding access through Community Based Outpatient Clinics (CBOCs).

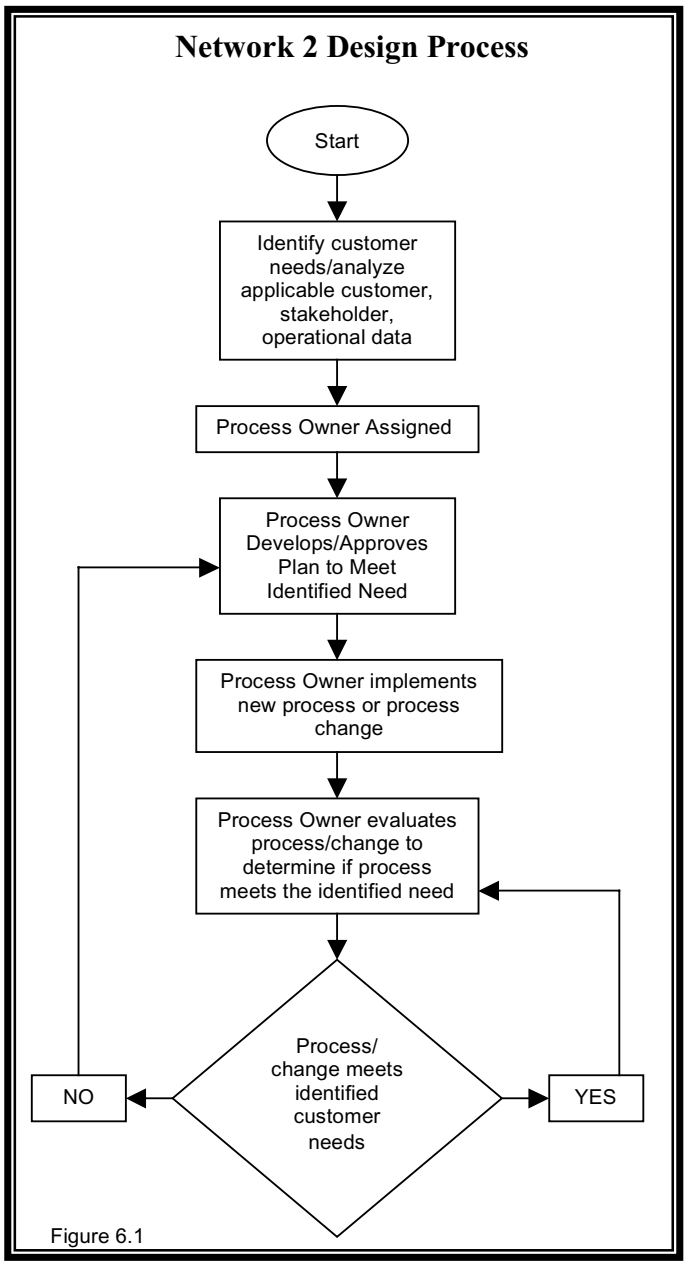
6.1a(2) Design Processes: The decision to launch new or modified health care services is subject to evaluation and approval of our ELC through the strategic planning process **(Cat 2.1)**. We consider market data, user demographics, economic/fiscal factors, mission changes and regulatory requirements. Our organization has used such information in determining the need for establishing additional CBOCs at key geographic locations as we endeavor to enroll more patients **(Fig 6.2)**.

New Service Delivery Example: Opening Community Based Outpatient Clinics		
KBD	**How Decisions Made**	**Performance Section 7 reference**
Patient Growth	‣ Market Penetration ‣ New Patients ‣ New vs. Lost Pts. ‣ Number of Pts	‣ 7.1A, 7.2A ‣ 7.1C ‣ 7.1D ‣ 7.5C
Customer Service	‣ Quick Card ‣ Outpt Satisfaction ‣ Clinic Wait Time	‣ 7.1E ‣ 7.1F-K ‣ 7.5K
Health Care Value	‣ Annual Budget ‣ Cost per Patient ‣ Cost per Outpatient Visit ‣ Staffing per Pt	‣ 7.2A ‣ 7.2B ‣ 7.2C ‣ 7.2D
Quality Health Care	‣ Standardized contract ‣ Mental Health Follow-up ‣ Chronic Disease Index ‣ Preventive Index ‣ Screenings	‣ 7.4A ‣ 7.5D ‣ 7.5E ‣ 7.5F ‣ 7.5G-J

Figure 6.2

6.1a(3) Changed Requirements: We incorporate changing patient needs and health care market requirements into our healthcare service design and delivery systems and processes by using the design process shown in **Fig 6.1**.

We used this design process to create the Dementia, Post Traumatic Distress Disorder and Substance Abuse Disease Management Programs, one of the ways we meet our key business driver, excellence in quality.



6.1a(4) New Technology: Network 2 has established a continuous methodology to evaluate and select new developments in medical technologies, medications and devices. Our process has been standardized in the Network Assessments of New and Existing Medical Technology Policy and Procedure **(Fig 6.3)**. Appropriate professional staff use objective criteria to determine the efficacy and applicability to our patient population, published scientific evidence related to clinical trials and VHA, and other government regulatory agency information. Our biomedical equipment assessments include compliance with manufacturer and VHA specifications, initial and ongoing preventive maintenance inspections, baseline values determination and documentation.

How Network 2 Used the Design Process to Open Community Based Clinics		
Cycle	**Step**	**How Implemented**
Plan	Identify Customer Needs/Analyze Data	ˇ Data analyzed: Customer Satisfaction **(Figs. 7.1E-K)**, number of patients treated **(Fig 7.5C)**, veteran market penetration **(Figs 7.1A, 7.2A)**
Plan	Process Owner Assigned	ˇ VISN 2 CBOC Council, a long term, formal team **(Cat 5.1.a.(1), (2)**
Do	Develop/Approve Plan to Meet Need	ˇ Multidisciplinary team (clinicians, administrators, union representatives, veterans) aligned plan with customer needs **(Cat 5.1.a(1, 2)**: ˇ Scope of design defined ˇ Needed resources identified, including requirements and constraints ˇ Time lines identified ˇ Measurements established for process control and outcomes ˇ Compliance with internal policies, regulatory requirements and standards, law ˇ Obtained organizational approvals
Do	Process owner implements change	ˇ Ensured required resources available (capacity met requirements) ˇ Monitored and controlled process parameters and outcomes: ˇ Established formal policies/procedures to define process controls ˇ Reduced variation through standardizations
Study	Evaluate process/change as appropriate	ˇ Evaluate performance/process measures: Cost per outpatient visit **(Fig 7.2C)**, CDI **(Fig 7.5E)**, PI **(Fig 7.5F)**, Screening **(Figs 7.5G-J)**, Veteran market penetration **(Fig 7.1A, 7.2A)**, percentage new patients **(Fig 7.3A)**, new vs. lost patients **(Fig 7.1D)**, patient satisfaction **(Figs 7.1E-K)**
Act	Continue to meet needs	ˇ Monthly review of operational data and customer, stakeholder feedback by CBOC Council to identify changes needed ˇ Quarterly review by TSPQ and ELC to ensure alignment with strategic and operational goals

Figure 6.4

Our review of new pharmacological agent reviews considers properties of the Food and Drug Administration recommendations. Results are communicated through our Network Pharmacy & Therapeutics Committee, our Network Pharmacy Manager, our local site pharmacies and are published in our Network newsletter. We maintain membership in the Health Technology Assessment Information Service (HTAIS), which provides a comprehensive, evidence-based examination of the clinical safety, efficacy and cost-effectiveness of healthcare technology compared to other clinical options for a defined patient population. We evaluate requests for new technology using the HTAIS.

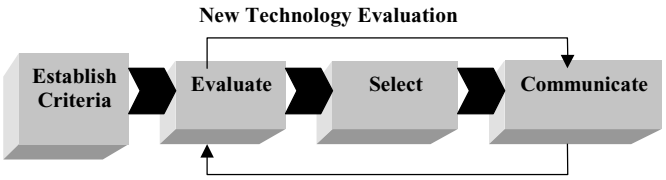


Figure 6.3

Network 2 communicates new technologies and procedures that are added to our member benefit package through our Network 2 website, member newsletters, specialized program brochures and targeted mailings, as appropriate.

6.1a(5) Spread of Best Practices: Our Network 2 improvement process follows the process design model defined in **Fig 6.1** with focus on the continuous assessment of our process and outcomes. The redesign of our clinic scheduling processes to reduce patient waits and delays illustrates how we have utilized the redesign process to improve health care service design and delivery **(Fig 7.5K)**.

When we review our performance and find a process that we consider to be a best practice, we disseminate the process across all sites through e-mail, meetings, newsletters and the Intranet. We have shared our best practices that were identified in the redesign of our clinic scheduling processes through the Network 2 Learning Sessions, where teams from our medical centers share best practices on improving wait times for our Primary Care, Eye Care, Audiology, Cardiology, Orthopedics and Urology Clinics **(Fig 7.5K)**. Using storyboards, our teams celebrate their successes, acknowledge their noble failures and train other teams for additional improvements. The Network 2 web site, Network 2 Employee Newsletters and presentations to our Executive Leadership Council are additional forums for organizational learning.

6.1a(6) Performance Requirements: Our Network 2 design process requirements include the establishment and leadership approval of performance measures and compliance with our internal policies, regulatory requirements and standards, and the law. We maintain concurrent accreditation in good standing with the Joint Commission on Hospital Accreditation, the College

of American Pathologists, the Nuclear Regulatory Commission (NRC), the National Council on Quality Accreditation and Rehabilitation Accreditation Commission (CARF) to ensure that we provide the community standard of care/service **(Fig 1.4)**. Visits from the VA Inspector General and visits from the Office of Safety and Health Administration (OSHA) assure that we are in regulatory compliance.

Network 2 Key Health Care Service Delivery Processes

Key Process (Reg'y Accred'n Req.) (Fig 1.14)	Requirements & Measure	Goal (Based on VA Best Practice or Community Benchmark)	How Improved
Patient Enrollment (NCQA)	▶ Increase patients treated **(Fig 7.3A)** ▶ Increase patient satisfaction scores **(Fig 7.1E-M)**	▶Increase the % of new patients seen by 23% ▶Increase the number of new patients seen by 48.9% ▶Reduce problems reported to Picker Institute benchmark	▶Increased the # of CBOCs **(Fig 6.2)** ▶Implement Quick Card to obtain real-time patient satisfaction information **(Fig 7.1E)** ▶Improve clinic wait times through redesign of scheduling processes **(Fig 7.5K)**
Diagnosis of Diseases & Conditions (JCAHO, CARF, CAP, NRC))	▶ Earliest detection of diseases and conditions ▶ Mammograms **(Fig 7.5H)** ▶ Prostate Cancer Screening **(Fig 7.5G)** ▶ Cervical Cancer Screening **(Fig 7.5I)** ▶ Major Depression Screening **(Fig 7.5J)**	▶96% of women will receive a mammogram ▶89% of men will be screened for prostate cancer ▶99% of women will be screened for cervical cancer ▶93% of patients will be screened for major depression	▶Establishment of women's health clinics **(Cat 3.1)** ▶All patients receive Personal Health Guide **(Fig 6.6)** ▶Use of General Health Questionnaire (GHQ) in Primary Care Clinics **(Fig 5.1)**
Treatment of diseases and conditions (JCAHO, CARF, NRC)	Provide cost efficient and effective treatments in a timely manner ▶30-day Follow Up after Mental Health Discharge **(Fig 7.5D)** ▶Pharmacy Cost per Patient **(Fig 7.2F)** ▶Acute Bed Days of Care **(Fig 7.2G)** ▶Shorter wait for appointment **(Fig 7.5K)**	▶96% of patients discharged will receive follow-up ▶Pharmacy cost: $526 per patient ▶750.5 Acute bed days of care per 1000 pts ▶Reduce average wait times in Primary Care, Eye Care, Audiology, Cardiology, Orthopedics & Urology Clinics to less than 30 days	▶IHI Waits and Delays Collaborative ▶Utilization Summit to reduce pharmacy costs without compromising quality of care **(Cat 4.1)**
Disease Prevention, Health Promotion & Health status (NCQA,	Promote healthy living practices & habits ▶CDI Measures **(Fig 7.5E)** ▶PI Measures **(Fig 7.5F)** ▶QuitSmart® Smoking Cessation Programs ▶Case Management Implementation	▶CDI completed for 96% of patients ▶PI completed for 88% of patients ▶QuitSmart® Program will be offered at all sites ▶Case management will be implemented at all sites	▶Sharing of best practices across sites for implementation of screening tools in Primary Care ▶Adoption of single smoking cessation program for Network 2; NEC funded ▶NEC sponsorship in case management training

Figure 6.5

6.1a(7) Coordination and Testing: Our health care service design and delivery processes are coordinated through appropriate professional staff councils and our Transforming Systems Performance and Quality Council. Among the methods we use to ensure trouble-free and timely introduction of health care services are the use of pilot programs and participation in the design testing of new VA-wide initiatives. Our Dementia Disease Management Program was piloted at one site, prior to its export to the other sites in Network 2 (key process: treatment of diseases and conditions). VHA initiatives among which we have participated in are HRLink$, the VHA state-of-the-art personnel and payroll system and process (key support process: education and development of staff). Our experience in Network 2 and feedback helps to improve these processes prior to national deployment.

6.1b Production / Delivery Processes

6.1b(1),(3) Key Processes and Performance: Our organization's key health care service delivery processes, key performance requirements and applicable regulatory/accreditation requirements are illustrated in **Fig 6.5**.

6.1b(2) Expectations and Outcomes: Our patients are provided with multiple means to access information about our healthcare program and provide feedback for Network 2's consideration in its health care service delivery processes. **Fig 6.6 & 3.3** illustrate the various ways in which we accomplish this **(Cat 3.2a(1&2)**.

6.1b(4) Key performance requirements: Network 2 utilizes the same process for both defining and improving our health care service

Setting Patient Expectations and Outcomes

Program/Resource	Description	How Factored into Services
VISN 2 Rights and Responsibilities of Patients Policy	Establishes policy and procedure for the rights and responsibilities of patients, and provides opportunity whereby patients and staff are informed of those rights and responsibilities	♦ Posted in all patient care areas ♦ Included in patient handbooks ♦ Posted on the VISN 2 Web Site
Personal Health Guide	Patient education on preventive health care	♦ Facilitates discussion between provider and patient ♦ Involves patient as partner in healthcare process
Veterans Health Benefits Booklet	Comprehensive list of healthcare benefits	♦ Defines eligibility for veteran health care, enrollment, claims filing, health care benefits
Patient Handbook	Lists access points for health care services	♦ Identifies sites of care and services available

Figure 6.6

delivery processes **(Fig 6.1)**. How we use key performance measures in effecting continuous improvement in our organization is illustrated in **Fig 6.4**.

6.1b(5) Process Improvement: Network 2 hosts a number of forums for continuous leadership review of our process measures and sharing of our best practices to support continuous process improvement, such as monthly Executive Leadership Council and monthly Performance Management Council reviews. We communicate improvements through our Network 2 employee newsletters, electronic bulletins to all our employees, inclusion on our Network 2 web site, our Pulse Points Performance Measures Report, desktop Decision Support Objects and our Network and local care line meetings.

6.2 Support Processes

6.2a(1) Key Support Processes: Our Network 2 key support processes and process indicators are illustrated in **Fig 6.7**. We identified our key support processes based on our indepth reviews and analyses which occur during our strategic planning process. Our support processes align with organizational responsibilities in our care line structure to support clinical care processes and are linked to all of our key business drivers.

6.2a(3) Meeting Key Requirements: Our organization designs, improves and deploys support processes in the same manner as defined in **Fig 6.1**. As illustrated in **Fig 6.2**, we identified key requirements, which were evaluated in the process for enrolling more patients, by expanding access through opening of additional Community Based Outpatient Clinics (CBOCs).

6.2a(4) In-process Measures: Network 2 has defined Network level policies and procedures that establish the criteria to be met by the key support processes. Standardizing the process helps us to minimize variation, allows us to use consistent measurement of indicators based on standardized data definitions, and provides us with performance measures that allow for our constant review and comparison among medical centers. We utilize internal, external and in-process criteria, as well as customer feedback, in ensuring that our support processes of education and development functions as we had intended.

6.2a(5) Support Process Improvement: We do

Network 2 Key Support Processes

Key Support Process	Methodology	Performance Requirements/Goals
Management of Information	• Strategic Information Council ensures alignment with strategic plans (monthly meeting) • Help Desk function accessible to all computer users	• Identification, project prioritization and status reporting of care line programming needs / projects (monthly) • Tracking percent of calls to the Help Desk with response times • Tracking percentage of hardware breakdowns with time to correct
Education and Development of Staff	• Network Education Council (NEC) • NEC Education Liaisons to care lines	• 98% of employees will receive 40 hours of continuing education (Fig 7.3D) • Meet OSHA Requirements
Environment and Facilities Management	• Network Safety and Health Program • Safety Officer appointed at each site	• Local Safety and Health Programs are established at all sites
Financial Planning	• Fiscal Coach assigned to each care line • Standardized process for fund allocation and movement among sites and care lines • Designated fiscal resources to support daily fiscal operations	• Credit card travel reimbursements within 3 working days of expense account submittal • Quarterly aged accounts receivables reports • Monthly reports of funds status • Daily status of allowances report • Quarterly review of budget excesses / surpluses

Figure 6.7

Network 2 Key Products and Services			
Key Products/Services	**Performance Indicators**	**Review Cycle**	**Reviewed by**
Contract - facilities maintenance, construction	Contractor Performance Report (quality of services, timeliness, customer service, cost control, business relations, compliance with labor standards)	Upon completion of contract requirements	» Contract Officer Technical Representative (VHA originator) » Contracting Officer
Contract - medical services	Contractor Performance Report (quality of services, timeliness, customer service, cost control, business relations, compliance with labor standards)	Upon completion of contract requirements	» Contract Officer Technical Representative (VHA originator) » Contracting Officer
Contract - CBOCs	Quality Performance Measures (CDI/PI) **(Fig 7.5E, 7.5F)** Patient Satisfaction **(Quick Card Fig. 7.1E)**	Monthly	» Contract Officer Technical Representative (VHA originator) » Contracting Officer » CBOC Council
Contract - Pharmaceuticals Prime Vendor	Fill rate on drug and pharmaceutical orders for next-day delivery **(Fig 7.4C)**	Monthly	» Diagnostics & Therapeutics Care Line » Network Pharmacy Manager
Contract - Medical/Surgical Prime Vendor	Fill rate for medical/surgical supply orders for delivery within 72 hours	Monthly	» Local A&MM Team Leader
Contract Nursing Homes	Cost per patient; # of patients; # bed days of care; price per patient compared to Medicare reimbursement; assessment of patient condition; compliance with local and state regulations	Monthly and Bi-monthly	» Registered Nurse (bi-monthly) Social Worker (monthly)
Contract Adult Day Health Care	# Patients, # visits, # admissions, #discharges, total cost, transportation cost	Monthly	» Purchasing Agent
Contract Homemaker Home Health Aide	# Patients, # hours of care provided, average cost / patient, average hours / patient, patient satisfaction	Annual	Patient Satisfaction Survey reviewed by Homemaker Home Aide Work Group, Purchasing Agent
Logistics - inventory/supply needs	On-time delivery, receipt of goods without damage	Monthly	Purchasing Agent

Figure 6.8

regular performance reviews at both the Network and local medical center levels. On a Network level **(Cats 1.1b(1&2)),** the process indicators are a standing agenda item for our monthly Executive Leadership Council meetings and are the subject of our monthly Performance Management Council meeting. Our medical centers review the indicators on a site-specific basis at the monthly Local Leadership Council. Unacceptable process variations, or poor performance, require the process owner to formulate a recovery plan addressing the cause of poor performance, corrective and preventive actions, responsible individuals and timelines for amending the problem. We accomplish organizational learning and sharing through several venues, as described in category **6.1b(5) (Fig 1.4)**.

6.3 Supplier and Partnering Processes

6.3a(1) Key Purchased Products/Services: The key products and services procured by Network 2, our performance requirements, and review cycles are illustrated in **Fig 6.8.** We have established sharing agreements with community organizations and providers to share limited medical resources **(Fig 7.4B)**. We review each agreement in accordance with contract requirements, using a subject matter expert and a Contract Officer (purchasing professional).

6.3a(2) Performance Requirements: We incorporate performance requirements into all purchase orders and contracts. Meeting all technical requirements with on-time delivery are standard for our purchases, with additional quality requirements based on end user specifications, as appropriate.

6.3a(3) Compliance with Requirements: Our end users assess recurring needs and purchases over $100,000 with our purchasing staff via the Contractor Performance Report. Our weighted performance elements include quality of services, timeliness of performance, customer service, cost control, business relations, and compliance with labor standards.

6.3a(4) Cost Minimization: Network 2 procurement practices used to minimize costs include commodity standardization, large volume purchases, use of VHA nationally negotiated contracts, purchase card programs and JCAHO accredited vendors to reduce duplicate inspections.

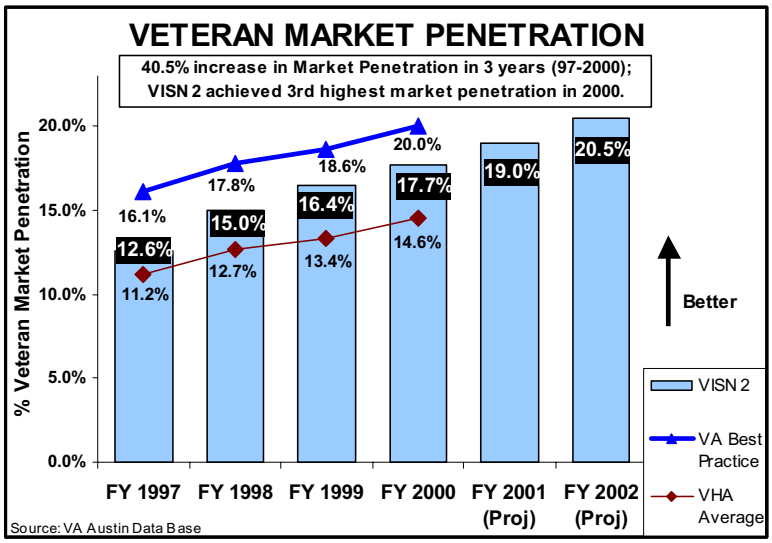
6.3a(5&6) Improvements and Incentives: The purchasing function is an integrated, Network-wide team. Technical experts work with the clinical and administrative end users. Purchasing identifies strategic objectives based on end user and vendor feedback, and works collaboratively to fulfill objectives.

7.0 BUSINESS RESULTS
7.1 CUSTOMER FOCUSED RESULTS

A. Veteran Market Penetration-(Key Driver-Patient Growth)

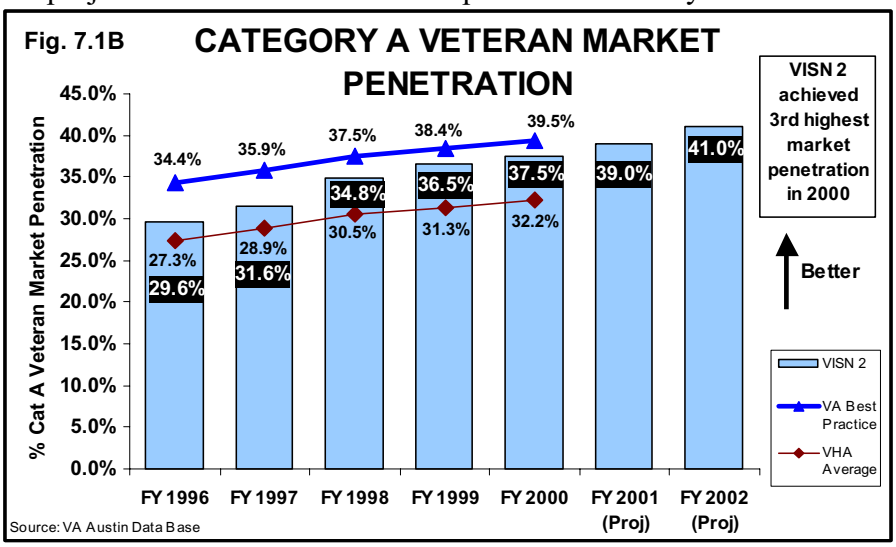
VISN 2 achieved a **17.2%** market penetration rate in FY 2000, treating 101,260 out of the total 571,370 veterans in Upstate New York's primary service area, the 3rd highest market penetration among 22 VA networks. Nationwide, the percentage of veterans seen is 14.6%. The **62.6%** increase in veteran growth projected for the 5 year period 97-2002, compares favorably with 1997 Baldridge Winner, Xerox Business division, in which sales increased 100% in 10 years. Network 2 continually benchmarks with the best organizations, both within and outside the health care industry, and incorporates innovative strategies and best practices.

Fig. 7.1A



Evaluation & Improvement of Processes: Marketing and outreach efforts have been developed in accordance with monthly evaluation of market penetration rates. Network 2 is currently on pace to achieve a projected 20.5% veteran market penetration rate by the end of Fiscal Year 2002.

Fig. 7.1B



B. Veteran Market Penetration among Medically Needy Veterans-(Key Driver-Patient Growth)

Market share was increased for low income or medically needy (Category A) veterans, to 37.5%, achieving the 3rd highest market share among 22 Networks (Phoenix =39.45%).

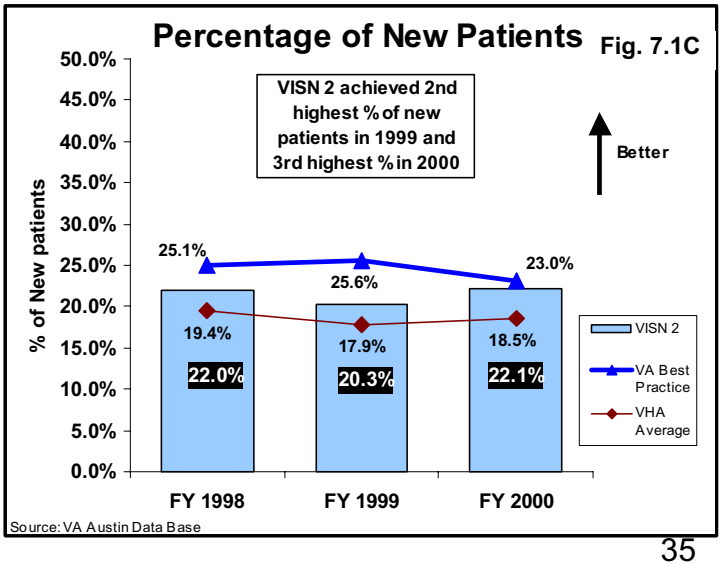
Evaluation & Improvement of Processes: Monthly results are used to develop additional action plans including outreach efforts among medically needy and minority veterans, with plans created to achieve 41% of low-income veteran market penetration by 2002.

C. New Patients (Key driver-Patient Growth)

Network 2 added 32,790 new patients to its health care system in FY 2000, 22.1% of its total patient base. This is in indicator of organizational success in expanding market share, most notable in an area of declining veteran population.

Evaluation & Improvement of Processes: Results are used to evaluate effectiveness of outreach

Fig. 7.1C

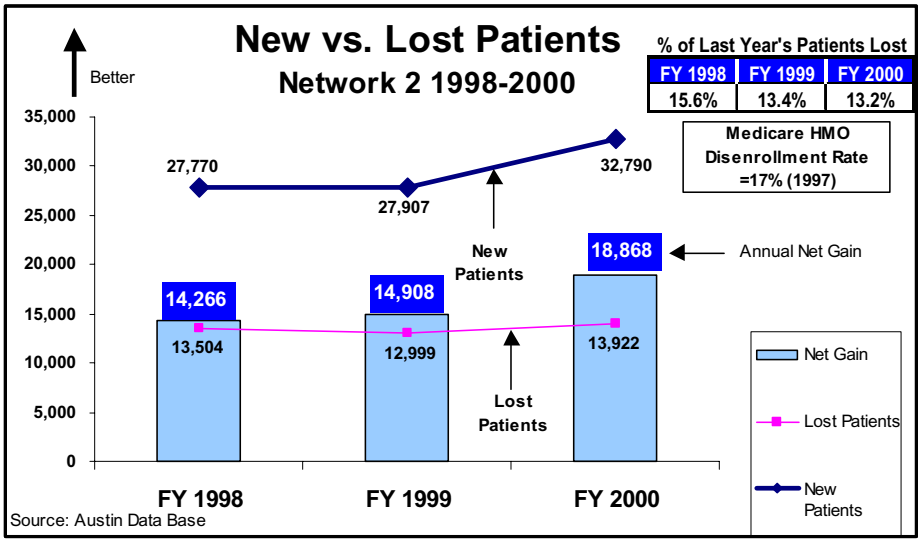


efforts, and where necessary, to consider new locations for community based clinics.

D. New vs. Lost Patients (Key Driver-Patient Growth)

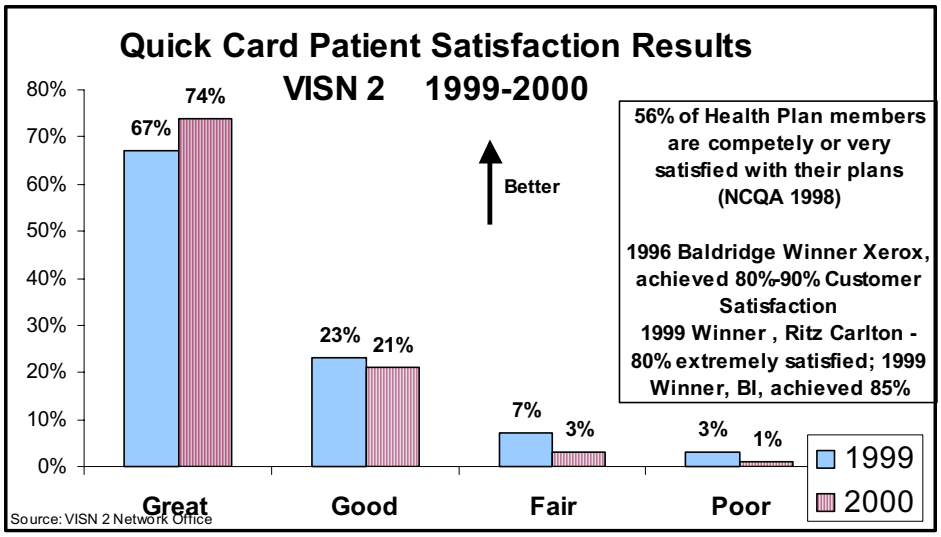
Network 2 has successfully retained approximately 87% of FY 1999's patients, while adding an additional 32,790 patients in FY 2000, achieving a net gain of 18,868 patients. The 13.2% rate of patient loss in 2000 is significantly less than the 17% Medicare disenrollment rate in 1997 (the last full year of available HCFA data)

Fig. 7.1D



Evaluation & Improvement of Processes: Results are used to develop direct mailings and follow-up phone calls to maximize retention of patients. Greater outreach efforts coupled with planned improvements in patient satisfaction, have resulted in projected increases in patients through 2006 (Figure 7.5C)

Fig. 7.1E



E. Quick Card Patient Satisfaction (Key Driver-Customer Service)

Quick card results, used to assess satisfaction with a patient's health care experience, showed significant improvement in 2000, with **95%** of all patients rating their care as great or excellence. This feedback tool was developed by VISN 2 and therefore no national norms within VA are available. Network 2 has been recognized for its Quick Cards as a best practice and has presented nationally at the 2000 VA Consensus Congress. This tool assesses courtesy, timeliness, confidence in provider, respect for privacy, sensitivity to concerns, facility cleanliness and health information. Network 2 assesses customer satisfaction against the best in health care (NCQA) as well as world class organizations including Xerox and Ritz Carlton, aiming to increase "great" ratings to the **80th** percentile.

Evaluation & Improvement of Processes: The utility of the quick cards is in the immediate feedback made available to staff and the corresponding staff action taken to improve customer service. Review of results has led to the next phase of reporting of Quick Card Data. In the upcoming year, Network 2 will implement a database that will enable real time reporting of Customer Satisfaction Data directly from the Intranet Site.

Fig. 7.1F

F. Overall Outpatient Satisfaction

Network 2 generated the greatest improvement in outpatient satisfaction scores since 1996; reducing the percentage of problems reported from **22.41%** in 1996 to **15.31%** in 2000, an improvement of **34.4%**. Network 2 achieved the **2nd best** overall outpatient score out of 22 networks. (VISN 1-Boston =14.84%). In addition to achieving the greatest overall improvement, Network 2 also achieved the greatest improvement VA-wide for the following components of satisfaction: Courtesy (15% to 5.3%), Emotional Support (23% to 17.5%), Patient education (38% to 27.8%)and visit coordination (21% to 13.6%).

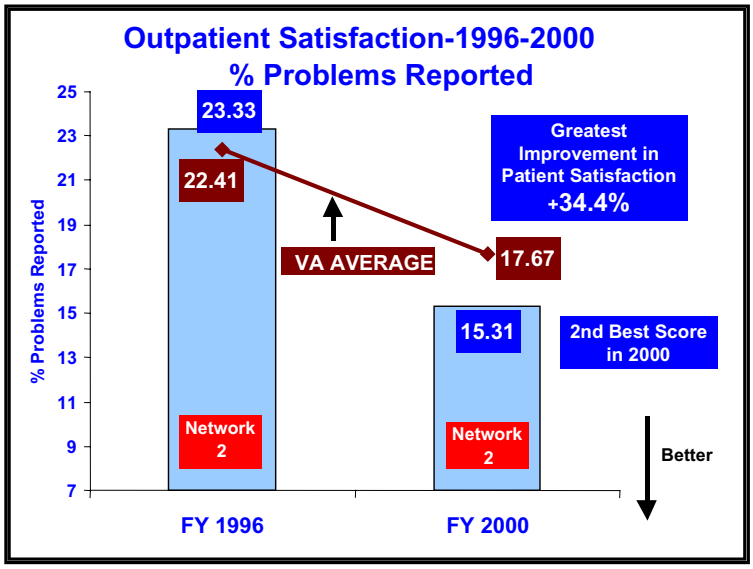
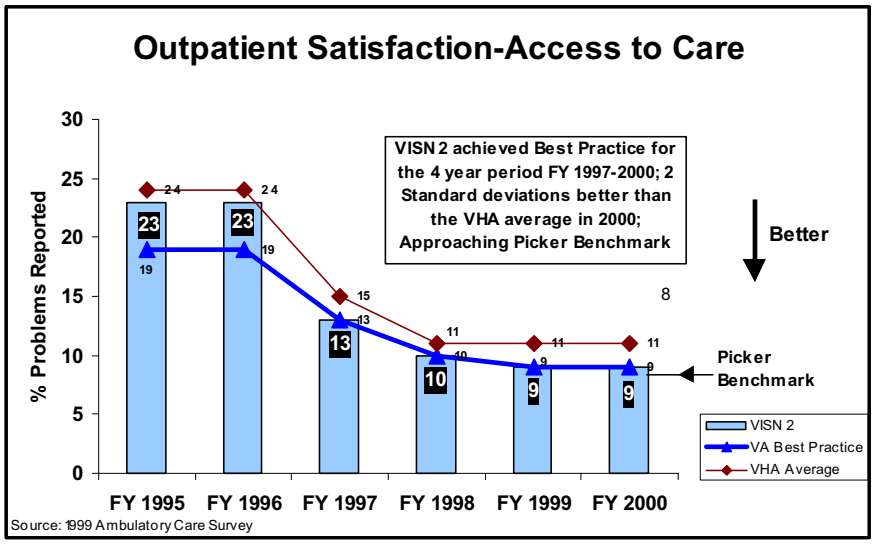


Fig. 7.1G



G. Outpatient Satisfaction Scores-Access to Care (Key Driver-Improve Customer Service)-

Network 2 continued to improve from 23% problems related to access reported in 1995 to **9%** in FY 2000, equaling **VA best practice for a 4 year period** 1997-2000. Generating the greatest improvement VA-wide in access-related satisfaction since 1995, Network 2 has systematically established 29 community based clinics for the added convenience of patients in remote geographical areas. The 9% score in 2000 is approaching the Picker Institute private sector benchmark of 7%.

Fig. 7.1H

H. Outpatient Satisfaction Scores-Courtesy (Key Driver- Customer Service)

Achieving the greatest improvement since 1995 in satisfaction pertaining to courtesy (**5% problems**), Network 2 equaled **VA best practice** for both1999 & 2000. Network 2 is approaching the Picker Institute benchmark of **4%.**

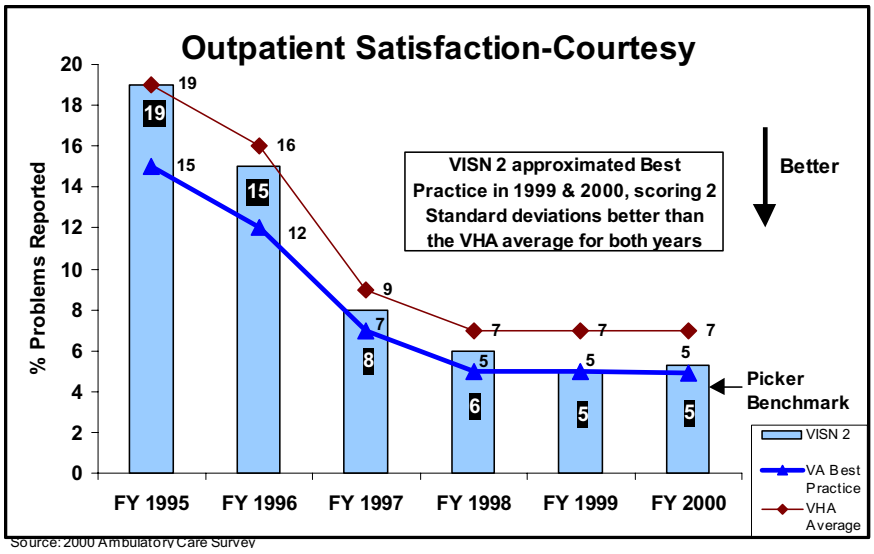


Fig. 7.1I

I. Outpatient Satisfaction Scores-Coordination of Care (Key Driver- Customer Service)-

VISN 2 continued to improve in the percentage of problems related to coordination of care, achieving **VA best practice** in FY 2000, 2 standard deviations better than the VA average.

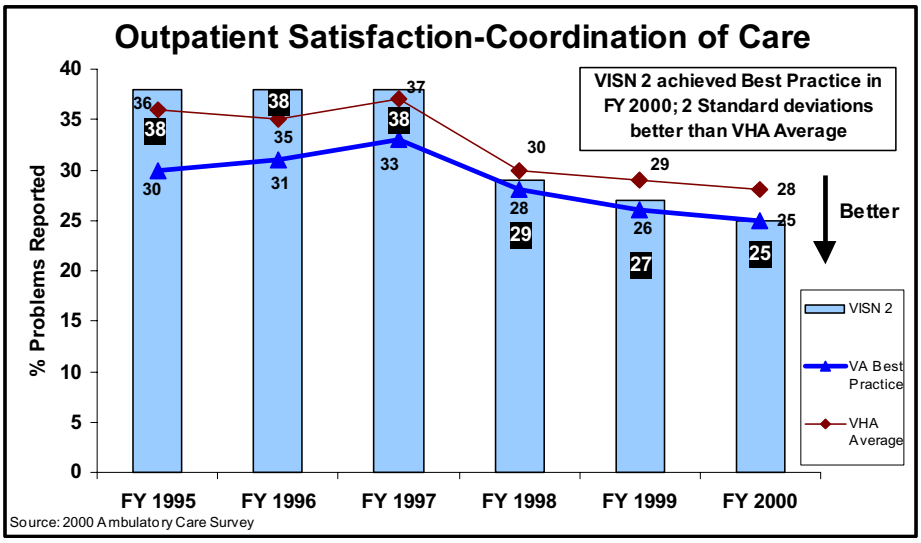
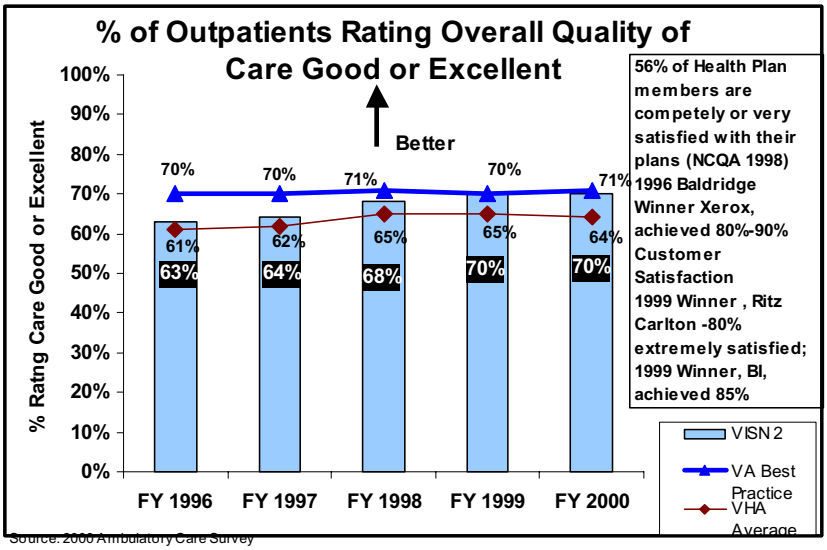


Fig. 7.1J



J. Outpatient Satisfaction Scores-% Rating Care Good or Excellent (Key Driver Customer Service)-

70% of all outpatients rated overall quality of care good or excellent in 1999 & 2000, the **2nd highest score** to Network 1 (Boston). Network 2 continues to benchmark with the best organizations, both within and outside of health care, aspiring to achieve the 90th percentile from NCQA (**78%**) while also examining 1999 Baldridge winner Ritz Carlton with customer satisfaction rates of 80%- or 1999 winner BI, achieving 85%.

Fig. 7.1K

K. 2000 Outpatient Satisfaction Survey (Key Driver-Customer Service)

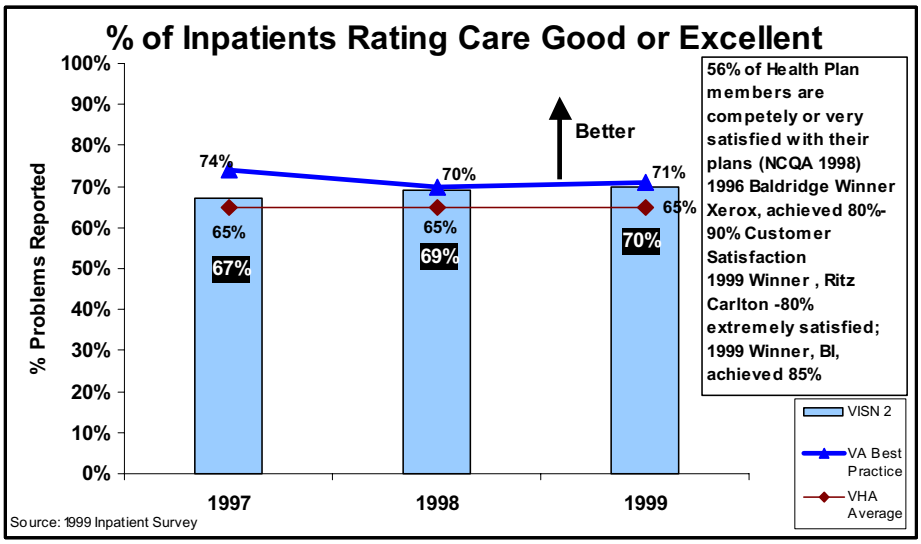
Network 2 achieved a an outpatient composite score of **18.164**, the **2nd highest** among 22 networks (Network 1=18.012).***Evaluation & Improvement of Processes:*** The results of all components of outpatient satisfaction surveys are reviewed by senior leaders as well and front-line staff, with problem areas

OUTPATIENT SATISFACTION SURVEY 2000

	Percent of Problems				
Component	Network 2	(+/-)	National Average	VHA Best Practice	Picker Benchmark
Access	9.2	(+)	11.4	9.2	7
Continuity	22.6		23.3	16.3	NA
Courtesy	5.3	(+)	7.1	4.9	4
Emotional Support	17.5	(+)	20.0	15.7	8
Overall Coordination	25.1	(+)	27.9	25.0	NA
Patient Education/ Info	27.8	(+)	30.4	26.6	20
Pharmacy	15.7	(+)	19.1	13.1	NA
Preferences	18.8	(+)	20.6	17.6	10
Specialist	26.5	(+)	32.1	26.5	NA
Visit Coordination	13.3	(+)	15.4	13.0	6
TOTAL	18.164		20.725	18.012 *	NA

(+) 2 Standard Deviations Better than VHA Average
* Network 1 (Boston) achieved the best composite score, narrowly ahead of Network 2

Fig. 7.1L



resulting in action plans to improve specific areas of veteran satisfaction.

L. Inpatient Satisfaction Scores-% Rating Care Good or Excellent (Key Driver-Customer Service)-

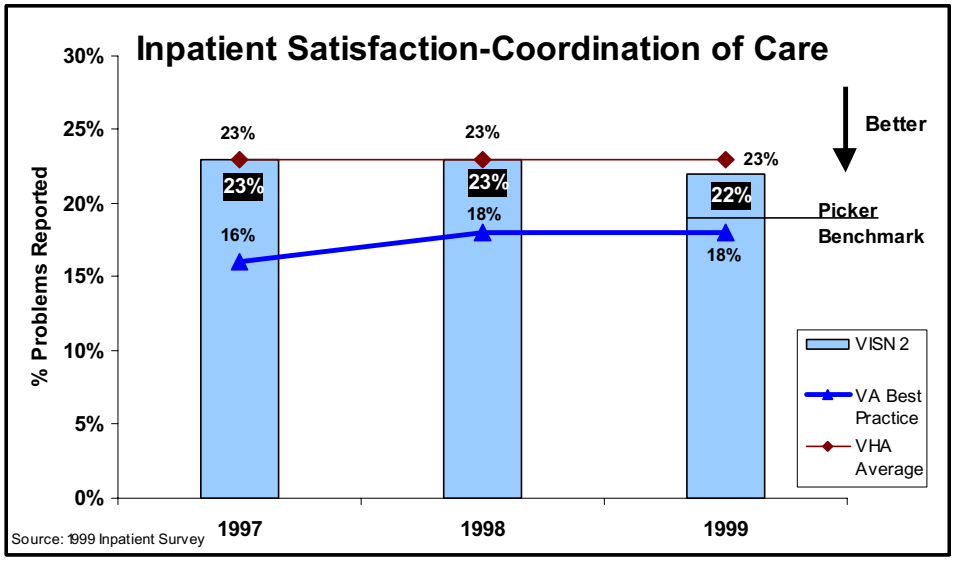
70% of all inpatients rated overall inpatient care good or excellent, tying for **2nd highest** score among 22 networks, 2 standard deviations better than the VA average of 65%.

Fig. 7.1M

M. Inpatient Satisfaction Scores-% Inpatients Reporting Problems –<u>Coordination of Care</u> (Key Driver- Customer Service

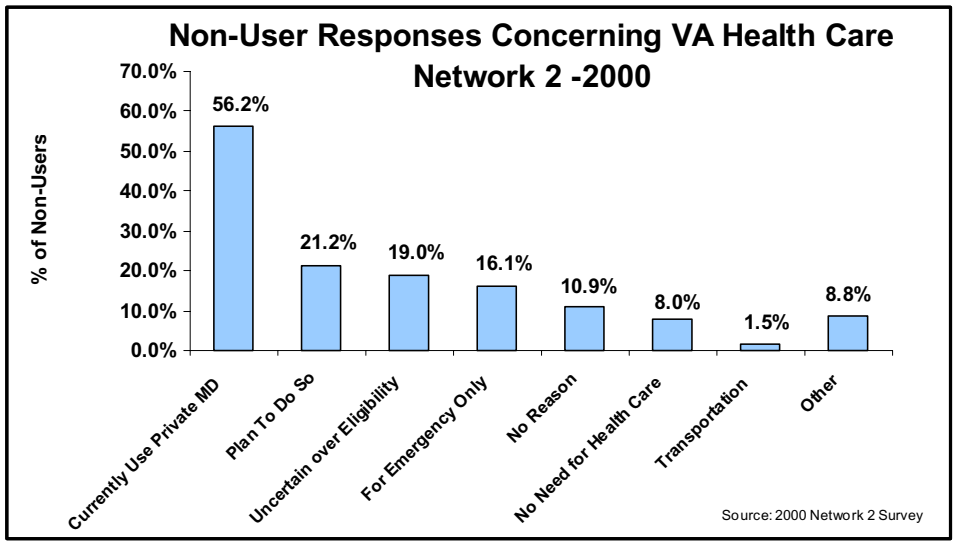
Improvement in coordination of care are shown at left.

Evaluation & Improvement of Processes: Results for this traditionally problematic area within both VA & private sector (see Picker benchmark), have been shared with front-line staff, with current systems under evaluation.



N. Survey of Non-Users of VA Health Care

Fig. 7.1N



(Key Driver- Customer Service

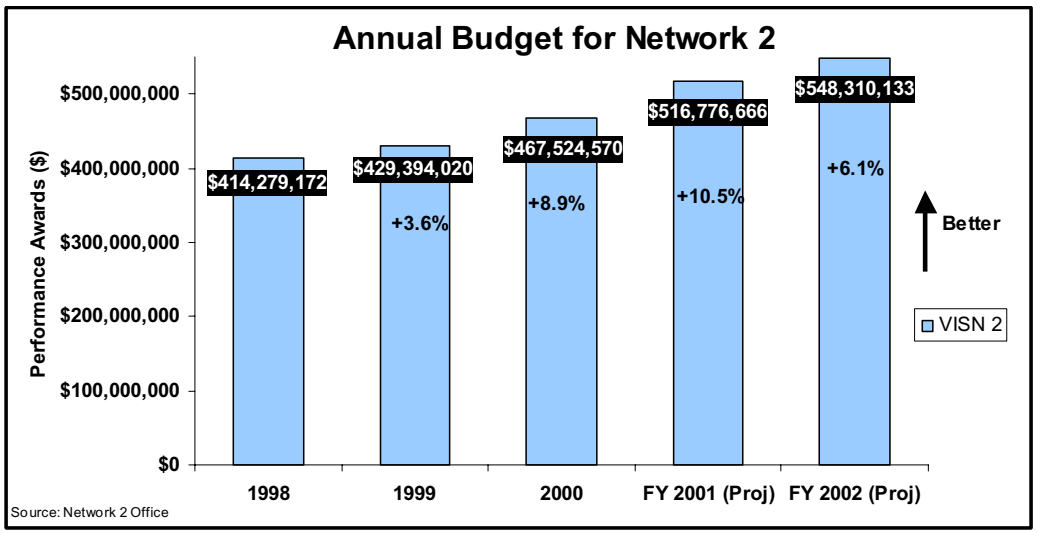
Veteran Non –Users were surveyed in order to better understand reasons for not seeking VA health care. While the majority of non-users have private physicians, uncertainty over eligibility constitutes a significant percentage.

Evaluation & Improvement of Processes: Network 2 has clarified eligibility requirements and has disseminated

information through fliers and the Network 2 Website to attract new patients.

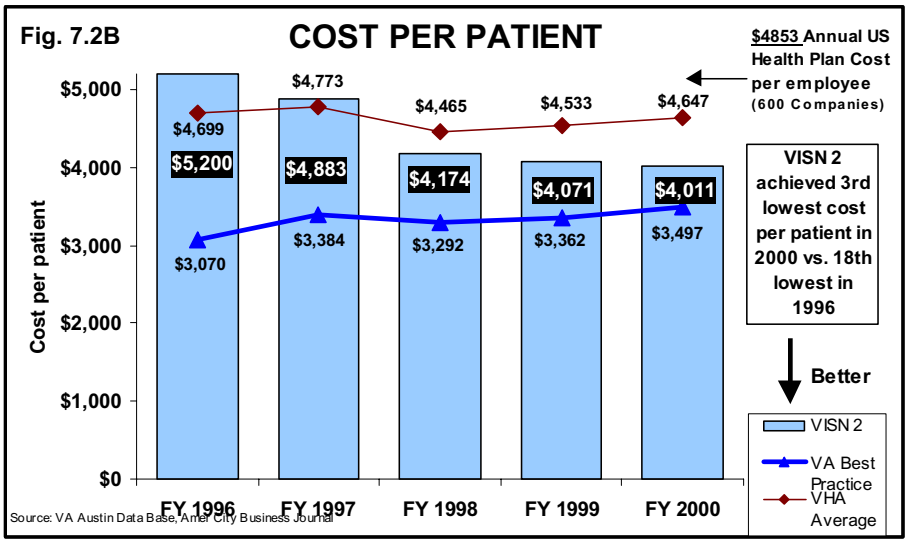
7.2 Financial Performance Results

Fig. 7.2A



A. Annual Budget (Key Driver-Health Care Value)
Network 2 has generated improved budgets in each of the last several years through enhanced performance as measured by the Veterans Equitable Resource Allocation (VERA) Model, the principal determinant of Network budget allocations. Budget increases from 2000-2002 exceed estimated medical inflation of 4.8%, identifying actual or planned programmatic growth above inflation.

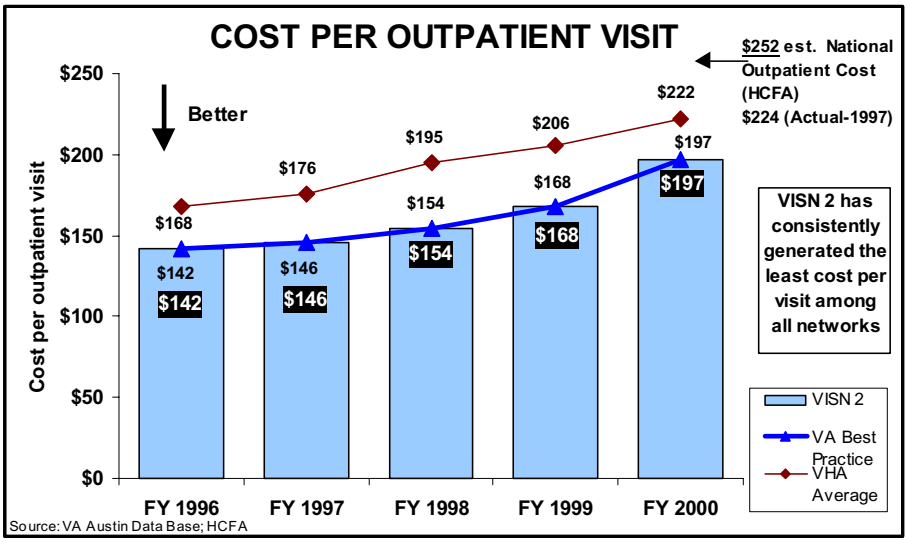
Fig. 7.2B



B. Cost Per Patient (Key Driver-Health Care Value)-
VISN 2 continued to demonstrate excellence in health care value, achieving the **3rd lowest** cost among 22 networks. VISN 2 reduced cost by **22.9%** between 1996 and 2000, the greatest reduction in cost per patient among all networks. VHA average cost remained largely unchanged during this period. The $4011 cost in 2000 is well below the annual US health plan cost of $4853 for 600 companies.

Evaluation & Improvement of Processes: Senior leaders review monthly unit cost reports to assure optimum resources utilization.

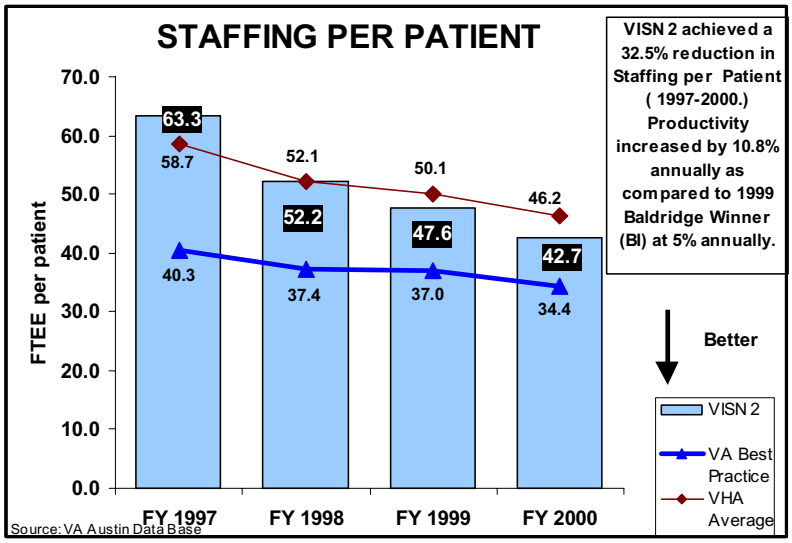
Fig. 7.2C



C. Cost Per Outpatient Visit (Key Driver-Health Care Value)-
Network 2 has demonstrated excellent health care value, producing the **lowest VA cost** per outpatient visit ($197) in 2000 and **21.8% below** the estimated US national costs of $252 (HCFA). Cost per visit increased by 38.7%

between 1996-2000, 9.7% per year, due largely to the planned redirection of staff and resources to outpatient programs, specifically ambulatory surgery, coupled with inflationary increases of 4% annually. ***Evaluation & Improvement of Processes****:* Cost data is reviewed by Senior leaders with efficiencies continually introduced including expansion of community based clinics, which have contributed significantly to outpatient cost successes.

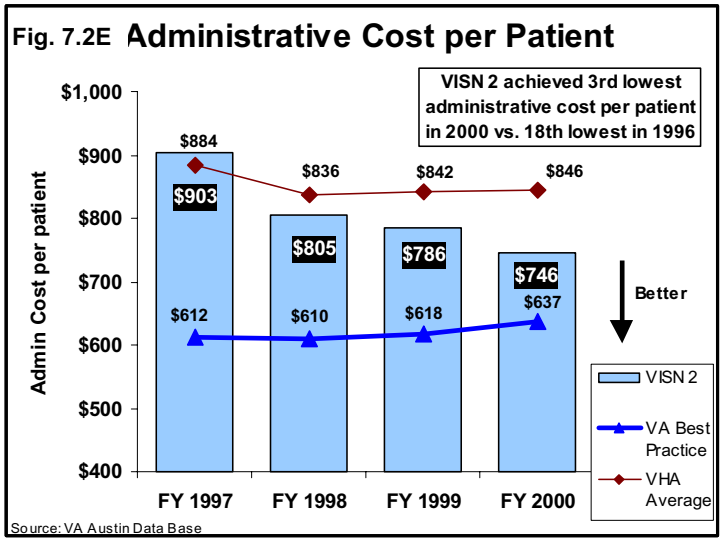
Fig. 7.2D



D. Staffing Per Patient (Key Driver Value)
Total full time employee equivalents (FTEE) per patient decreased by **32.5%** between 1997 and 2000, the greatest improvement in staff productivity among all 22 networks. ***Evaluation & Improvement of Processes****:* Senior leaders review monthly unit cost reports to assure optimum resources utilization. Staff reengineering has resulted in continual improvements in overall employee productivity.

E. Administrative Cost Per Patient (Key Driver-Health Care Value)-

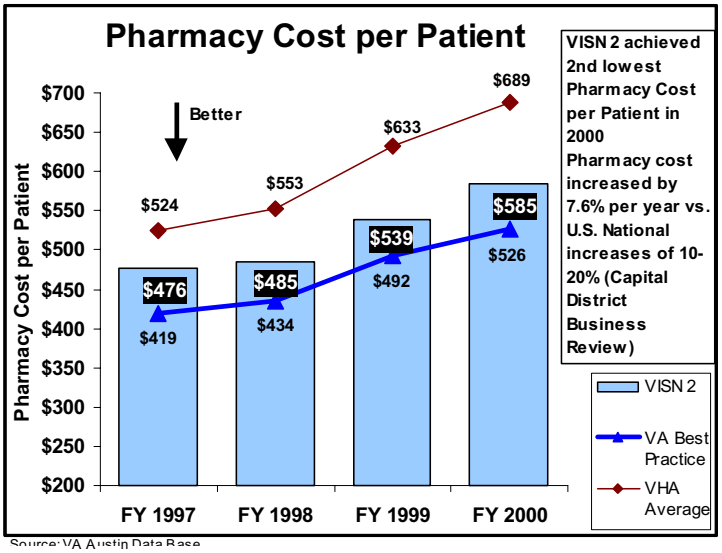
Fig. 7.2E



Administrative Cost per patient decreased by **17.4%** between 1997 and 2000, achieving the **3rd lowest unit cost** among 22 networks. VHA average cost has continued to increase since 1998 including VHA best practice (VISN 18-Phoenix). Network 2 administrative costs equal **18.6%** of total, compared with US health care plan costs among for-profit companies of 14.3%. ***Evaluation & Improvement of Processes****:* Senior leaders and care line managers review monthly unit cost reports to assure that a greater percentage of costs are devoted to direct patient care. Cross training of staff, and application of new technologies have generated consistent improvements.

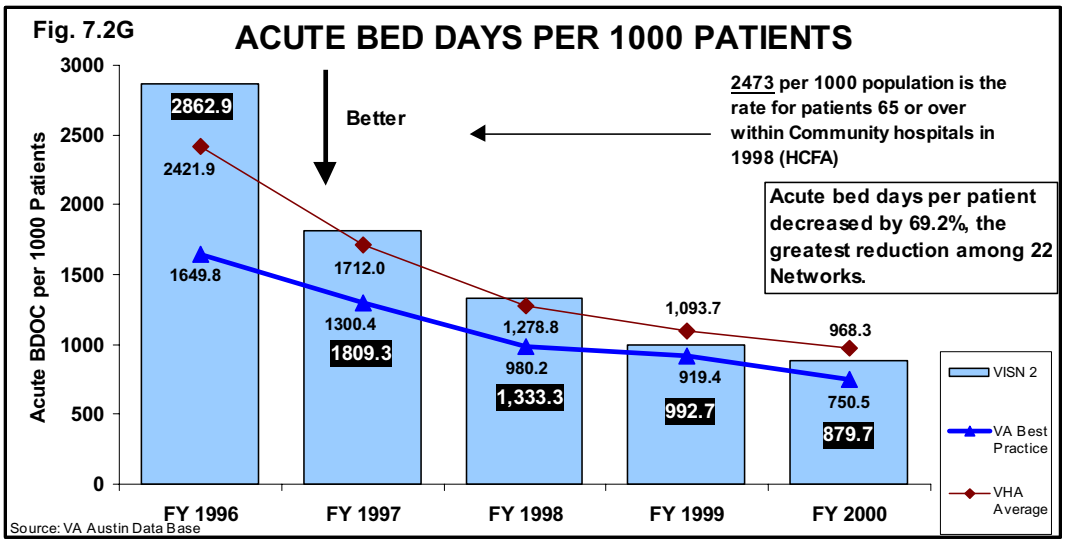
F. Pharmacy Costs (Key Driver- Value)
Pharmacy costs per patient have been effectively controlled, with only a **22.9% increase** since 1997. Pharmacy cost per patient is now the **2nd lowest** to VISN 18 (Phoenix). This **7.6%** annual increase is well below the US national increase of 15%. ***Evaluation & Improvement of Processes:***. A Network-wide Utilization summit was held in February 2000 to focus on pharmacy costs, non-formulary drugs, statins, SSRIs and Lansoperazole. Work groups have been formed to address

Fig. 7.2F



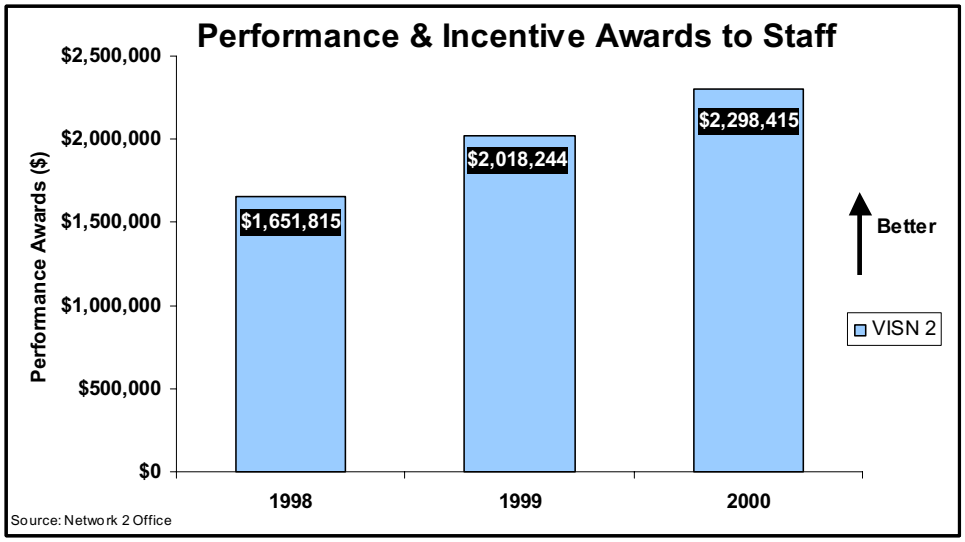
polypharmacy, standardization of non-formulary exceptions and electronic drug usage evaluations.

Fig. 7.2G



G. Acute Bed Day of Care (Key driver-Value)
Network 2 reduced bed days of care per 1000 patients by **69.2%** between 1996-2000, the greatest reduction among all networks. ***Evaluation & Improvement of Processes:*** Acute bed day of care reports are reviewed monthly by senior leaders and care line staff to assure optimum utilization. Network 2 improved its ranking from 20th in 1996 to 7th in 1999, the greatest improvement in comparative performance among all networks. This has served as an effective indicator of the degree to which VISN has transitioned from a hospital-based to a health delivery system.

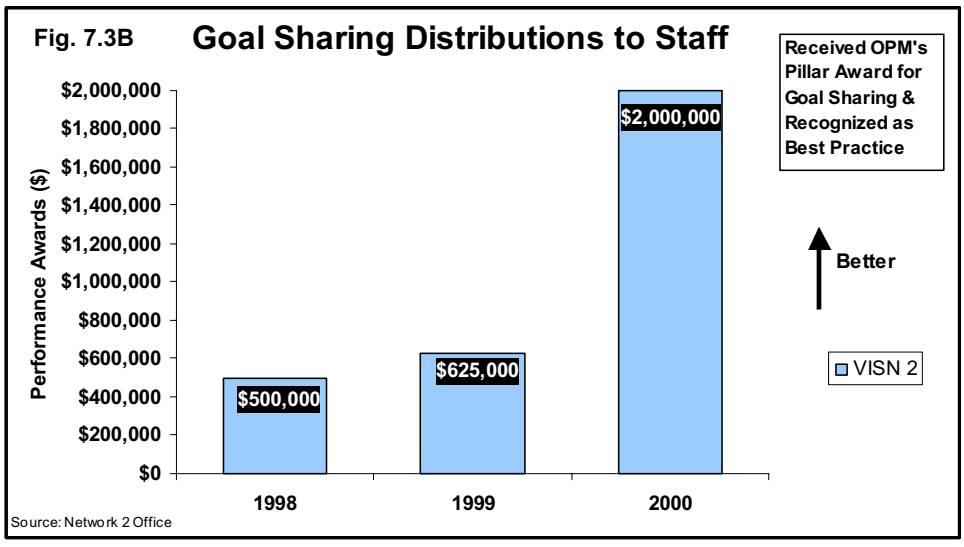
Fig. 7.3A



7.3 HUMAN RESOURCE RESULTS

A. Performance Awards to Staff 2000 (Key Drive-Quality)
$2.3 million was distributed in cash awards in 2000, recognizing staff for their contributions to organizational successes. ***Evaluation & Improvement of Processes:*** Senior leaders and local care line managers review performance award allotments at the unit level to assure fairness and appropriate staff recognition for achieving excellence.

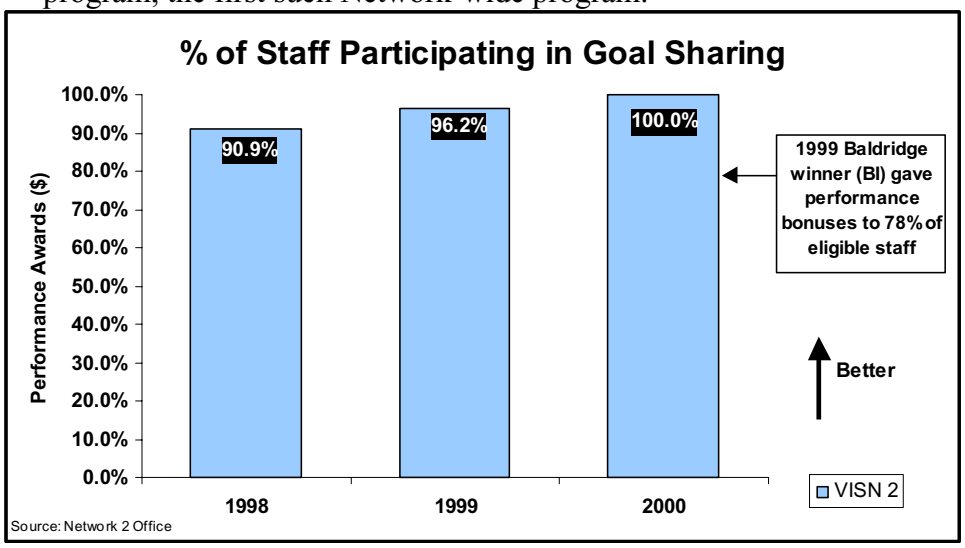
Fig. 7.3B



B. Goal Sharing Distributions to Staff (Key Driver-Quality)
Distributions for goal sharing have increased in proportion to achieved successes, specifically with stated organizational goals. Network 2 won Office of Personnel Management's (OPM's) **first annual Pillar Award** for its goal-sharing

program, the first such Network-wide program.

Fig. 7.3C



C. Goal Sharing Participants (Key Driver-Quality)

All staff have participated in the goal sharing program in FY 2000, VA 's first Network-wide program aligned to organizational goals.

Evaluation & Improvement of Processes: Goal sharing participants and allotments have continued to increase, with staff playing a larger role in the development of unit level goals in accordance with Network and VHA strategic direction

D. Employees Receiving Continuing Education –(Key Driver-Quality)

The percentage of employees receiving continuing education increased from 75% in 1998 to **96%** in 2000. 1997 Baldridge Winner Xerox Business Services spent **$714** per employee for training vs. **$342** per employee in Network 2. Network 2 continually benchmarks with world class organizations, both within and outside the health care industry.

Evaluation & Improvement of Processes: Senior leaders, Care Line staff, and the Network Education Council review unit level reports of staff continuing education in order to engender greater participation. New programs are developed in accordance with identified staff needs, applying new technologies including virtual learning modalities.

Fig. 7.3D

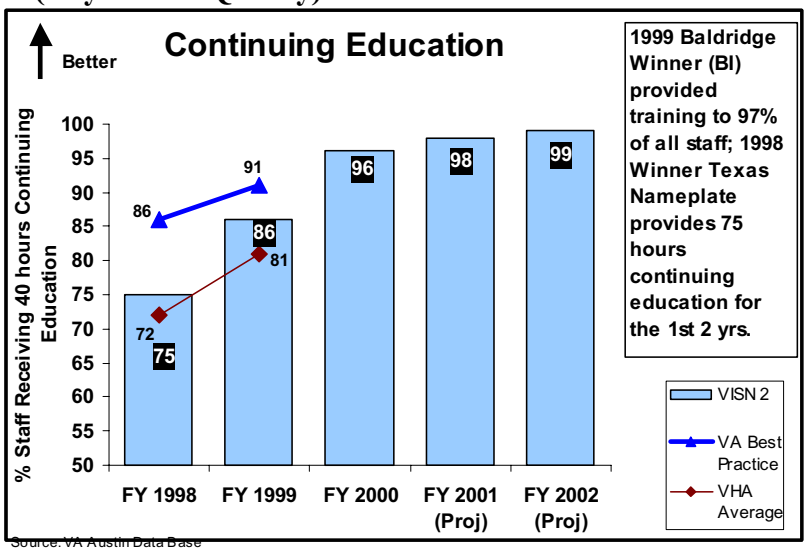
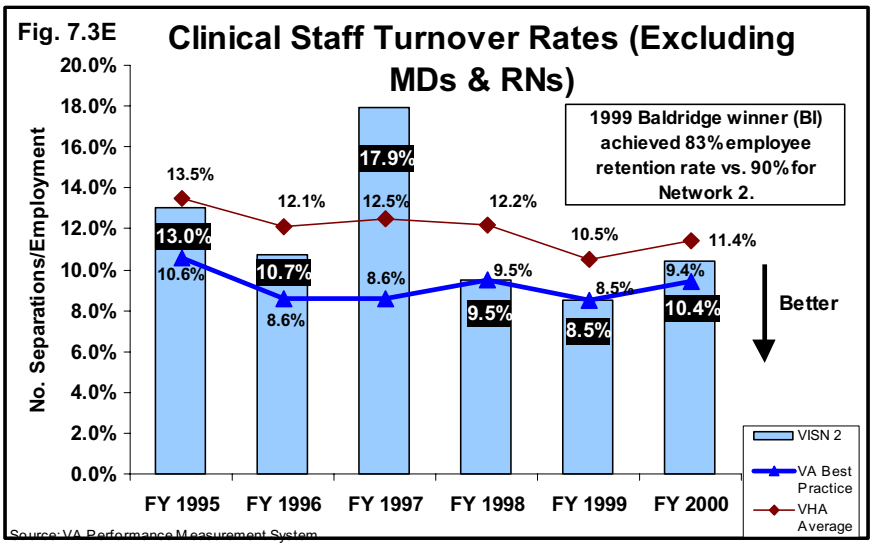


Fig. 7.3E



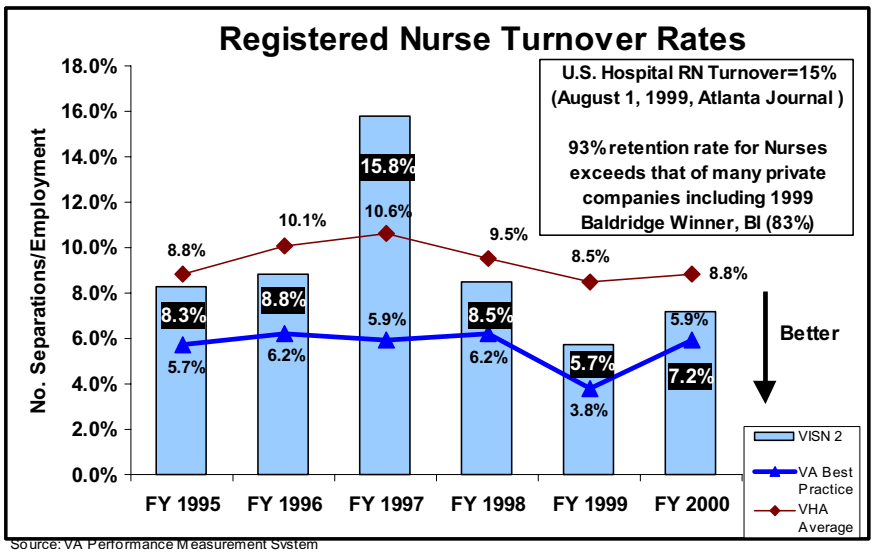
E. Clinical Staff Turnover Rates (Key Driver-Quality)

Network 2 has improved clinical staff turnover rates, equaling VA best practice in 1998 and 1999. The **90 %** retention rate in 2000 surpasses private sector organizations including 1999 Baldridge winner (BI) with a retention rate of 83%. The 17.9% turnover rate in 1997 was a result of required reductions in force and staff adjustments, due to budget deficits which have since been eliminated.

Evaluation & Improvement of Processes: Senior leaders and Care Line staff, review unit level turnover reports, with the goal of achieving maximum staff retention.

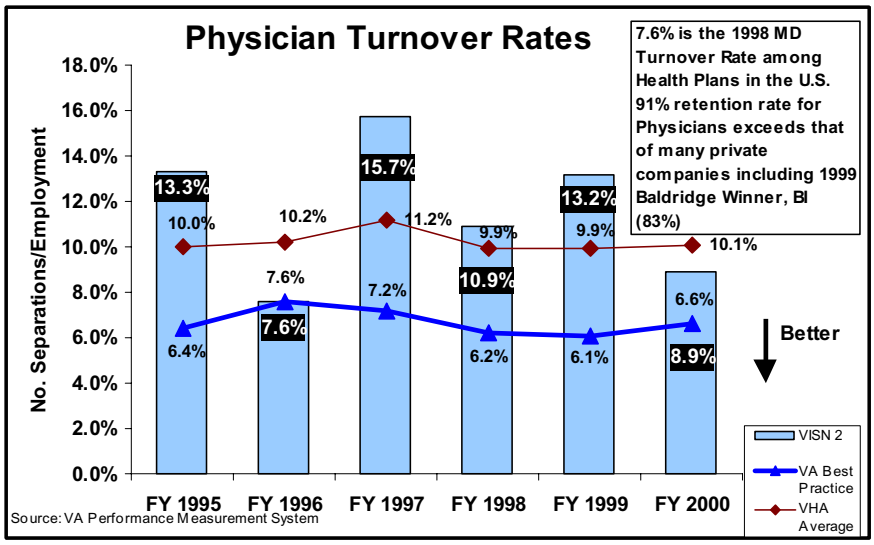
Fig. 7.3F

F. Registered Nurse Turnover Rates (Key Driver-Quality)
Network 2 retained greater than **92%** of registered nurse staff in 2000, significantly better than the U.S. hospital turnover rate of 15%. The 15.8% rate in 1997 resulted from staff adjustments due to 1997 budget deficits. ***Evaluation & Improvement of Processes:*** A nurse recruitment and retention work group was established, producing site-specific evaluations and strategies.



G. Physician Turnover(Key driver-Quality)

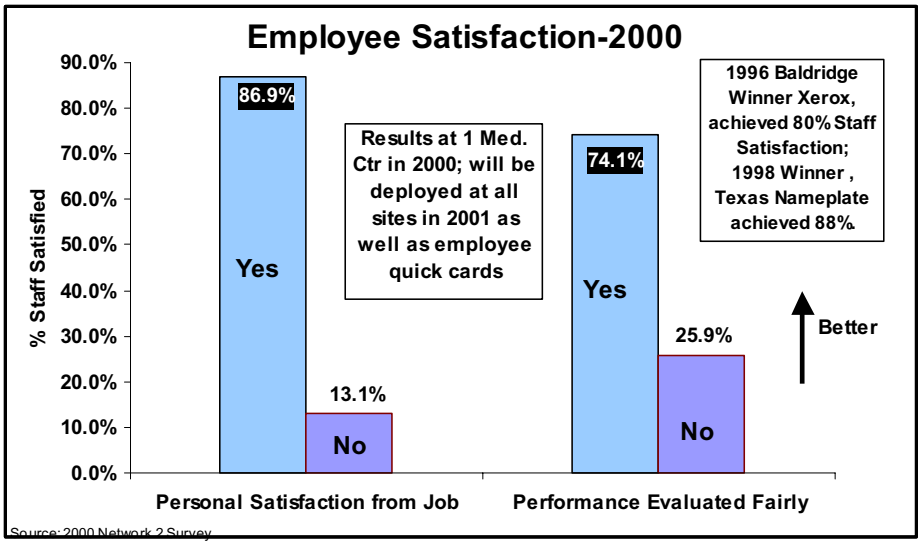
Fig. 7.3G



Physician Turnover rates improved to **8.9%** in 2000, comparing favorably with the 7.6% MD turnover rate among US health plans. ***Evaluation & Improvement of Processes:*** A network-wide evaluation of physician recruitment and retention was conducted in July 2000, with a presentation given to the Executive Leadership Council. Senior leaders work with each physician to enable their professional growth through academic affiliations, research opportunities and professional association.

Fig. 7.3H

H. Employee Satisfaction-(1 Site only) **(Key Driver-Quality)**
Network 2 has implemented employee satisfaction surveys, beginning at one site, with plans for expansion to all locations throughout 2001. **87%** of staff reported personal satisfaction from job, comparing favorably to Baldridge winning organizations including Xerox and Texas Nameplate. ***Evaluation & Improvement of Processes***. Greater



involvement in goal formulation, coupled with planned increases in incentive awards, are being implemented in 2001. Network 2 is initiating Employee Quick Cards, building on successes achieved with patient Quick Cards, to solicit timely staff responses and evaluations.

I. High Performance Development Model (Key Driver-Quality)
Over 90% of staff have been given orientation to the High Performance Development Model (HPDM), designed to develop skills for VA employees, in accordance with changing needs. ***Evaluation & Improvement of Processes:*** Staff development has been enhanced through HPDM training, coupled with training and educational opportunities in areas of identified need.

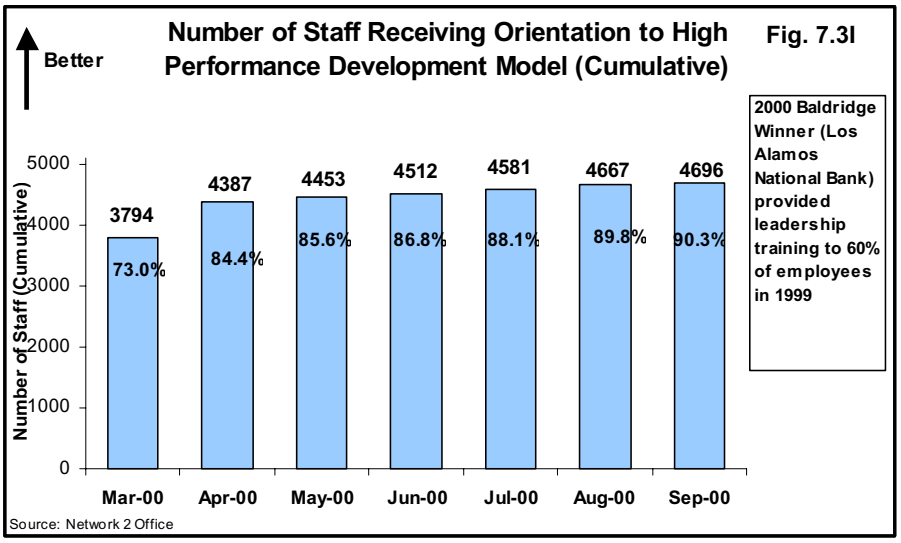
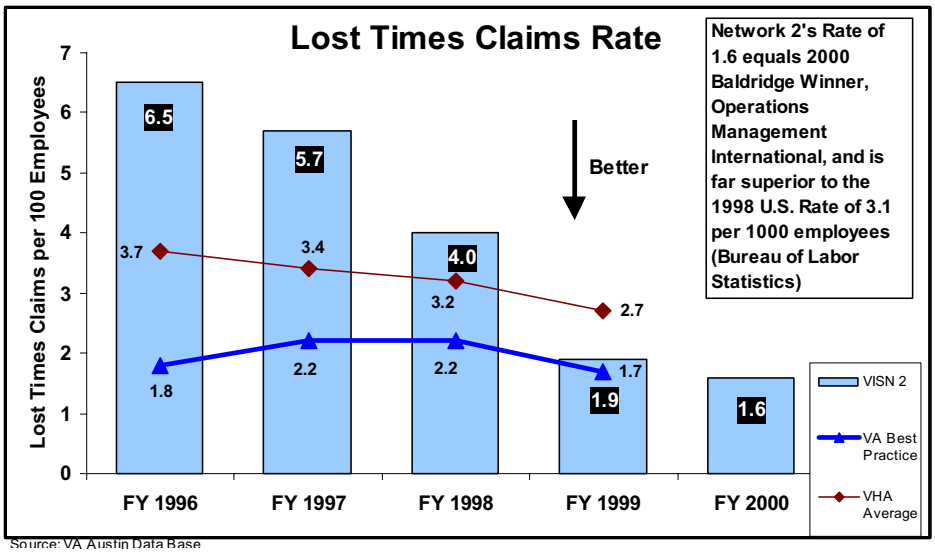
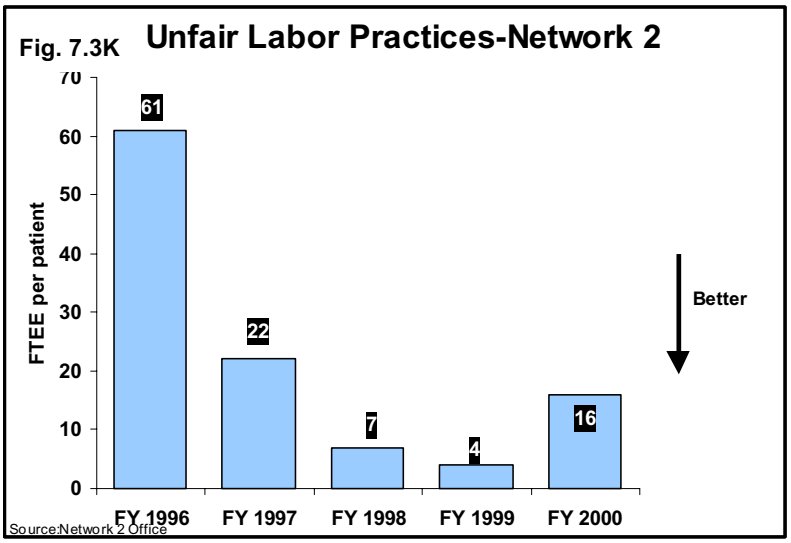


Fig. 7.3J



J. Lost Times Claims Rate (Key Driver-Quality)
Lost times claims rate decreased from 6.5 per 1000 employees in 1996 to **1.6** in 2000, a **75.4% reduction**, and the greatest improvement among all networks. VA best practice and averages for 2000 are unavailable due to national reporting problems. The 1.6 rate in 2000 is roughly half of the US rate (3.1) reported by the Bureau of Labor statistics. ***Evaluation & Improvement of Processes:*** Senior leaders and unit level staff review all lost time reports, improving performance through widespread employee education and use of light duty assignments.

K. Unfair Labor Practices- (Key driver-Quality) Unfair labor practices have been reduced significantly since 1996 through improved partnership and involvement of union membership. ULPs filed increased to 16 in 2000 as a result of a change in policy concerning nurse seniority, specifically related to weekend and evening coverage. ***Evaluation & Improvement of Processes:*** Additional management-union partnership meetings were



held, resulting in action plans. Network and labor leaders continue to negotiate on these issues and foresee a decline in the issuance of unfair labor practices. Union participation is notable on the Executive Leadership Council (ELC), a highly unusual practice across VHA, which characterizes Network 2's unique level of inclusiveness related to staff and union partners

7.4 SUPPLIER AND PARTNER RESULTS

A. Standardization of Contracts (Key Driver-Increase Health Care Value)
Approximately $1.8 million in cost savings was generated in FY 2000 by working effectively with suppliers.
Evaluation & Improvement of Processes:
Review of available reports have resulted in integration of Acquisition & Materiel Management programs throughout Upstate New York including effective negotiations with vendors and suppliers.

Fig. 7.4A

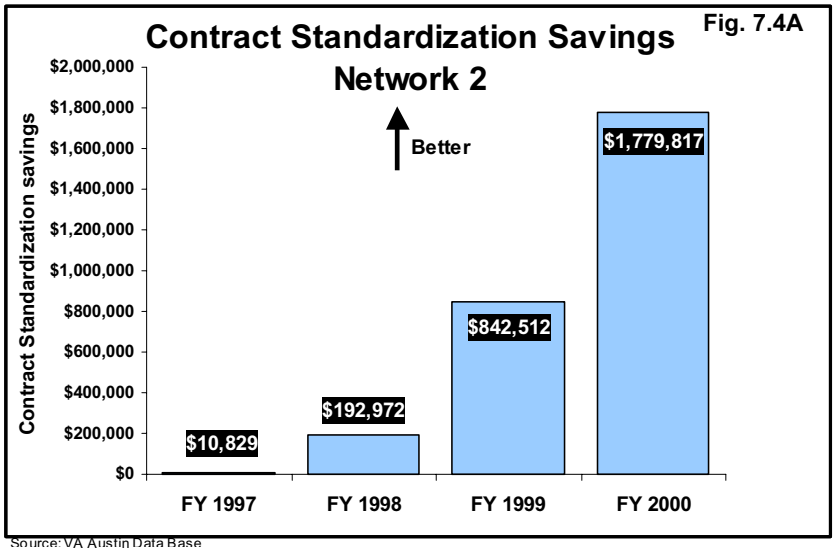
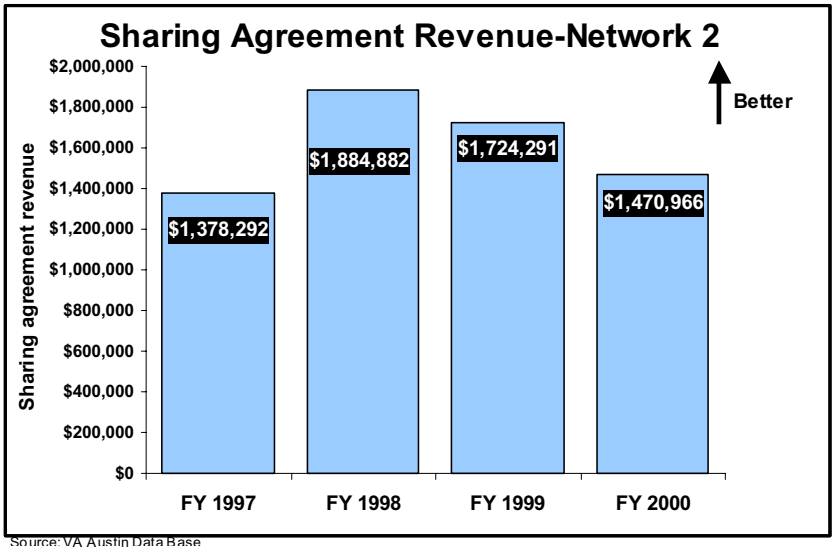


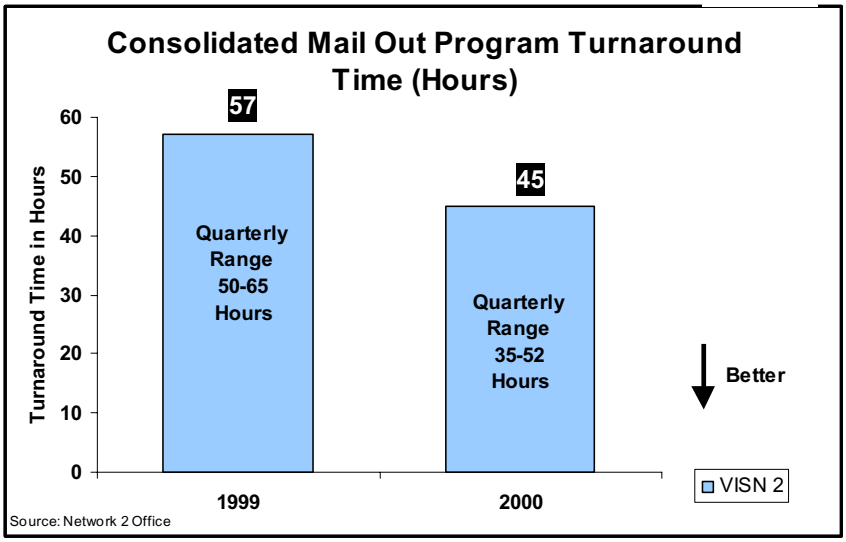
Fig. 7.4B



Evaluation & Improvement of Processes:
Network 2 is developing new agreements with insurance carriers for gamma knife surgery, for which Albany is one of the few providers nationwide, while developing enhanced lease projects for underutilized sites at Batavia & Canandaigua.

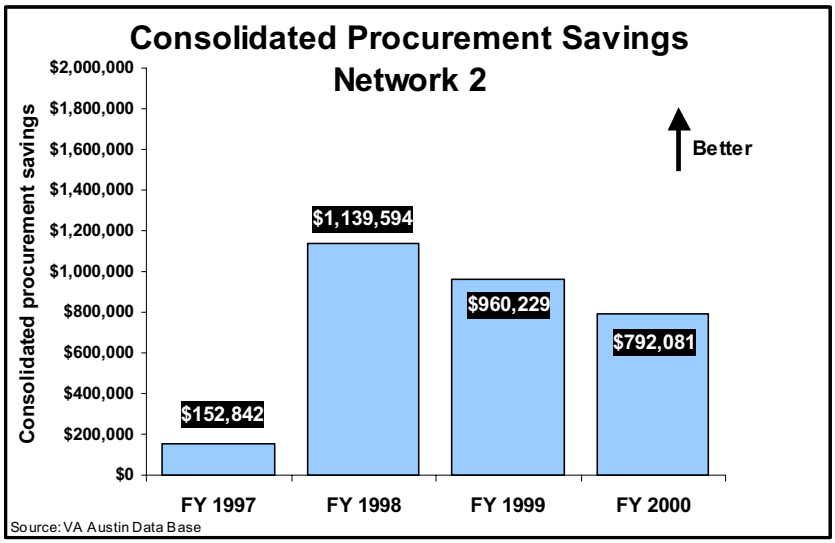
B. Income from Sharing Agreements (Key Driver- Value)
Network 2 has continued to establish effective working relationships with partners and providers across New York state, collecting $1.4 million in revenue in 2000. Recent reductions in revenue have resulted from declining TRICARE population at the major site (Syracuse) as the military continues to transition small units out of NY state. Reductions are also due to sharing partners developing in-house capacity for services including the INS recently completing in-house laundry operations.

Fig. 7.4C



C. Turnaround Time For Consolidated Mail Out Program (CMOP)
Turnaround Time provided by the Hines CMOP has improved to an average of 45

Fig. 7.4D



hours, as a result of a contract change from the Bedford, Mass, CMOP.

Evaluation & Improvement of Processes: In FY99, Network2 began collecting VISN-wide data as part of a plan to seek best practices. The Hines CMOP, was promoting excess capacity, shorter turnaround time, and lower charges. VISN 2 began the switch from the Bedford CMOP to the Hines CMOP during the 4th quarter of FY99 . 30 hour turnaround is projected for 2001.

D. Consolidated Procurement) (Key Driver-Customer Service) Approximately $800,000 in cost savings were generated in 2000, through ongoing network-wide approaches to group purchasing.

Evaluation & Improvement of Processes: Procurement leaders have studied purchasing reports and have collectively developed strategies to improve network-wide procurement efforts, resulting in significant cost savings.

Fig. 7.5A

Performance Ranks for 4 Key Drivers
(Out of 22 Networks)

PATIENT GROWTH (96-2000)		
1. VISN 4	Pittsburgh	+49.1%
2. VISN 2	Albany	+42.1%
3. VISN 8	Bay Pines	+40.6%

VALUE (2000)		
1. VISN 18	Phoenix	$3497
2. VISN 8	Bay Pines	$3857
3. VISN 2	Albany	$4011

CUSTOMER SERVICE (2000)

PATIENT SATISFACTION (6 Measures-% Problems)

1. VISN 1	Boston	14.84 %	(6 out of 6 2SD+)
2. VISN 2	Albany	15.31 %	(6 out of 6 2SD+)
3. VISN 4	Pittsburgh	15.85%	(5 out of 6 2SD+)

CLINIC WAITING TIMES-6 Clinics (Days)

1. VISN 19	Denver	27.3	(5 Exceptional)
2. VISN 5	Baltimore	27.5	(4 Exceptional)
3. VISN 2	Albany	30.4	(4 Exceptional)

QUALITY (2000)

PREVENTION INDEX — Clin. Pract Guidelines (Quadrant)

1. VISNs 16 & 21	(Jackson, San Fran)	88	I
2. VISNs 11 & 19	(Ann Arbor, Denver)	87	I
3. VISNs 2, 15, 16	(Albany, K. City, Port)	86	I

MENTAL HEALTH FOLLOW-UP

1. VISN 2 Albany	96.1	I
2. VISN 16 Jackson	95.0	I
3. VISN 5 Baltimore	91.6	II

7.5 ORGANIZATIONAL EFFECTIVENESS RESULTS

A. Performance Ranks (Key Driver-Quality) Network 2 achieved a top 3 ranking for all **6** of the following key performance indicators, while also achieving quadrant I for required clinical interventions, with no other network achieving a top 3rd ranking for more than **2** indicators.

B. Average Rank for 6 Key Performance Measures in 2000

Fig. 7.5B

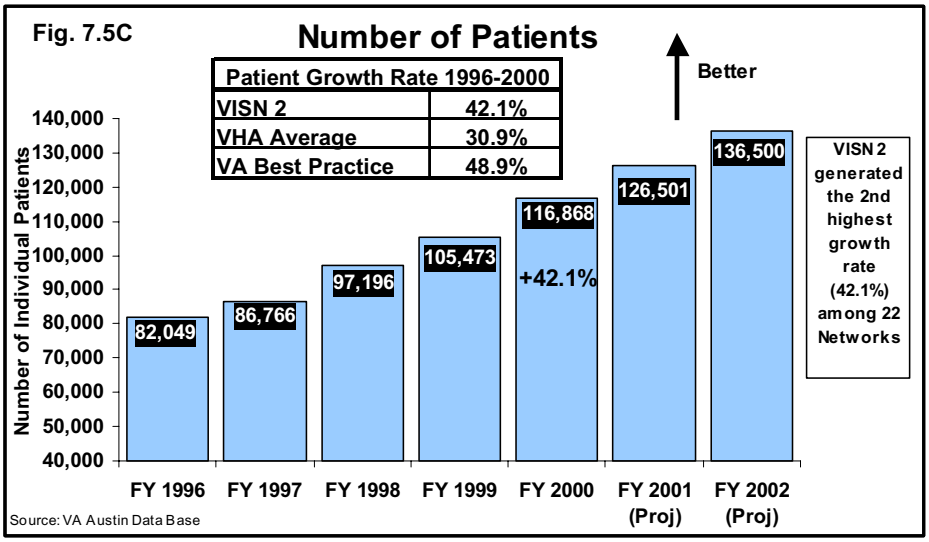
Average Rank for 6 Performance Measures
(Out of 22 Networks)

- Patient Growth
- Cost
- Patient Satisfaction
- Clinic Waits
- Prevention Index
- Mental Health Follow-Up

VISN	VISN Location	AVG. Rank (Out of 22)
2	Albany	2.67
19	Denver	6.50
15	Kansas City	8.33
21	San Francisco	8.33
16	Jackson,MS	9.00
20	Portland	9.50
4	Pittsburgh	9.83
18	Phoenix	10.33
7	Atlanta	10.50
13	Minneapolis	10.50
8	Bay Pines	10.67
14	Omaha	11.83
3	Bronx	12.33
5	Baltimore	12.33
9	Nashville	13.50
11	Ann Arbor	13.50
1	Boston	13.83
6	Durham	13.83
10	Cincinnati	14.67
17	Dallas	15.83
12	Chicago	16.67
22	Long Beach	18.50

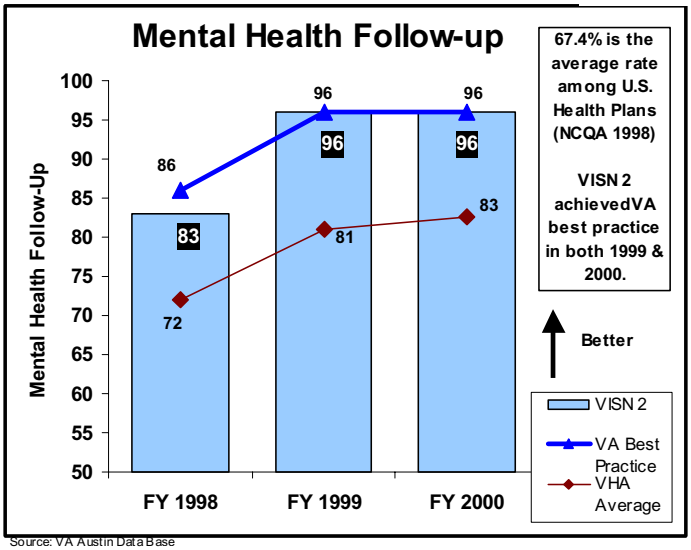
(Key Driver-Quality) Network 2 was ranked **1st** in overall performance for the 6 key performance measures in 2000, with an average rank of **2.67 out of 22** networks, an extraordinary level of consistency. The next highest ranked network (VISN 19-Denver) achieved an average ranking of 6.5 out of 22, with significant reductions thereafter. With the exception of Network 2, other VA networks performed relatively poorly in numerous measures, despite excelling in one or more.

Fig. 7.5C



C. Increases in Patients (96-00) (Key Driver-Patient Growth)- Network 2 achieved a +42.1% increase in patients since 1996, achieving the 2nd highest rate of increase compared to Network 4 (Pittsburgh). The 54% increase in patients projected for the 5 year period (96-2001), compares favorably with 1997 Baldridge winner Xerox Business Division, in which sales increased by 100% over 10 years. ***Evaluation & Improvement of Processes:*** Senior leaders review patient growth reports monthly in order to achieve optimum patient expansion. Most notable is that Network 2 expanded its patients so dramatically in a network experiencing a rapid decline in veteran population, owing to effective outreach efforts coupled with operational improvements. This achievement is testimony to Network 2's effectiveness in transforming its health care system, in the face of declining resources and population.

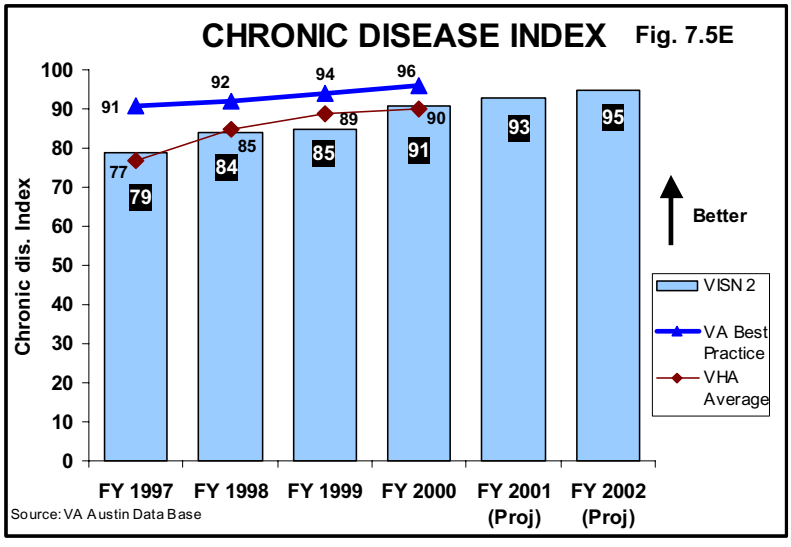
Fig. 7.5D



D. Follow-up to Hospitalization for Mental Illness- (Key Driver-Quality)

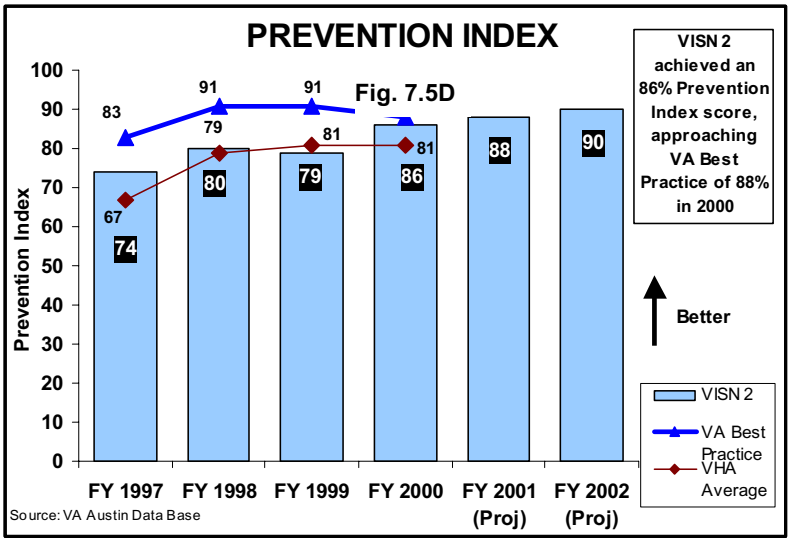
Network 2 achieved best practice in 2000 with a follow-up rate of **96%,** far surpassing the VA average of 83%. The Upstate New York Network has led on a national level in demonstrating procedural improvements and has consistently shared best practices at national conferences for the benefit of other networks. ***Evaluation & Improvement of Processes:*** Senior leaders and Behavioral Health staff review findings on a monthly basis and have effectively introduced procedural improvements. Network 2 has been recognized as a national leader in this area.

E. Chronic Disease Index (Key Driver-Quality)



Network 2 has shown continuous improvement in Chronic Disease Index achieving a score of **91%** for FY 2000. VISN 2 has developed a targeted score of 95% by 2001. ***Evaluation & Improvement of Processes:*** Senior leaders and Care line staff review reports on a monthly basis, and have issued procedural improvements in order to improve performance.

Fig. 7.5F

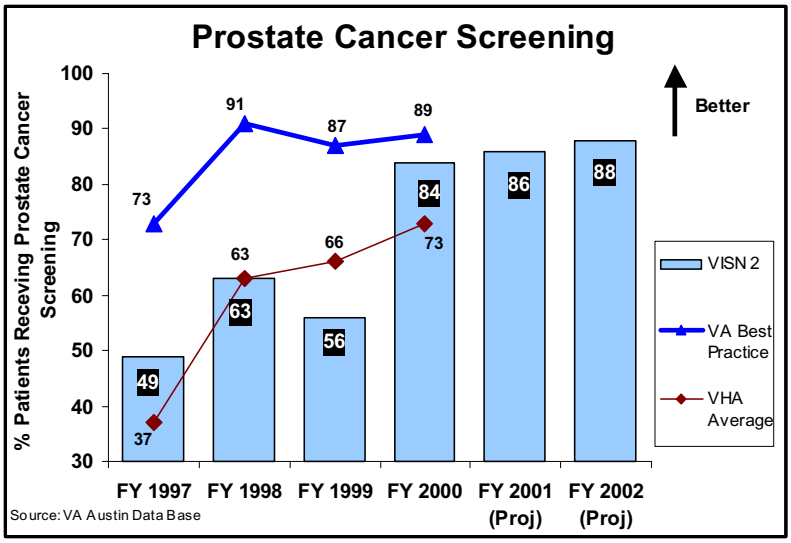


F. Prevention Index (Key Driver-Quality)
Prevention Index scores increased from 74% in 1996 to **86%** in FY 2000 as compared to a VA average of 80%.)

Evaluation & Improvement of Processes
Senior leaders and Care line staff review reports on a monthly basis, and have issued procedural improvements, leading in order to improve performance. VISN 2 has developed a targeted score of 88% by 2001 and 90% by 2002.

G. Prostate Cancer Screening (Key Driver-Quality)

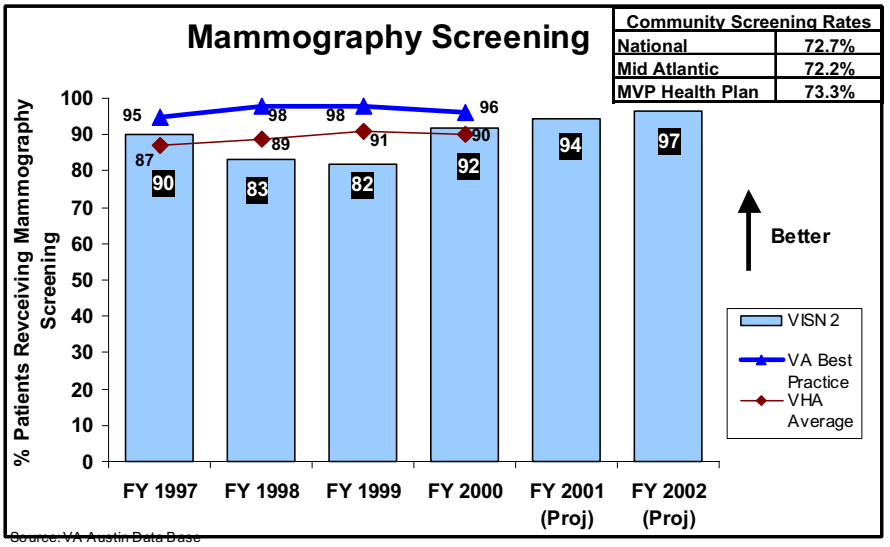
Fig. 7.5G



The percentage of patients screened for prostate cancer increased from 37% in 1997 to 84% in 2000. (According to the American Cancer Society (ACS), beginning at age 50, an annual prostate examination, including a digital rectal examination and a PSA test, should be offered annually to men who have a life expectancy of at least 10 years, and to younger men who are at high risk. However, the US Preventive Services Task Force has indicated that there is no current evidence to support annual PSA testing and DRE examinations for men over 50)

Evaluation & Improvement of Processes: Prevention Index reports, including specific screening rates, are reviewed monthly by Senior leaders and Care line staff. Procedural improvements have resulted in improved compliance rates. Targeted scores of 88% have been established for 2002.

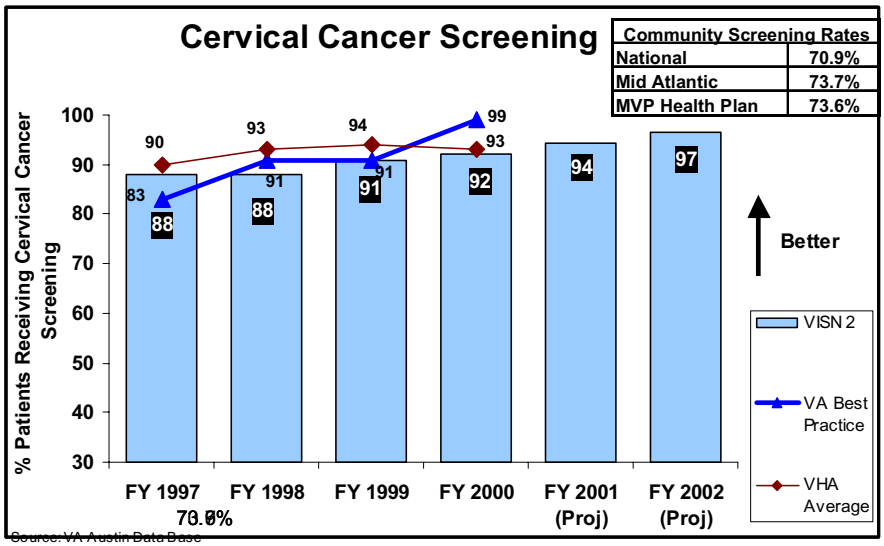
Fig. 7.5H



H. Mammography Screening (Key Driver-Quality)
The percentage of patients receiving mammography exams improved to 92% in FY 2000, surpassing community-screening rates of 72-73% (National, Mid-Atlantic & MVP Health Plan).

Evaluation & Improvement of Processes:: Senior leaders and Medical VA Care line staff review reports on a monthly basis, and have issued procedural improvements, leading to improved performance. VISN 2 has developed a targeted score of 97% by

Fig. 7.5I

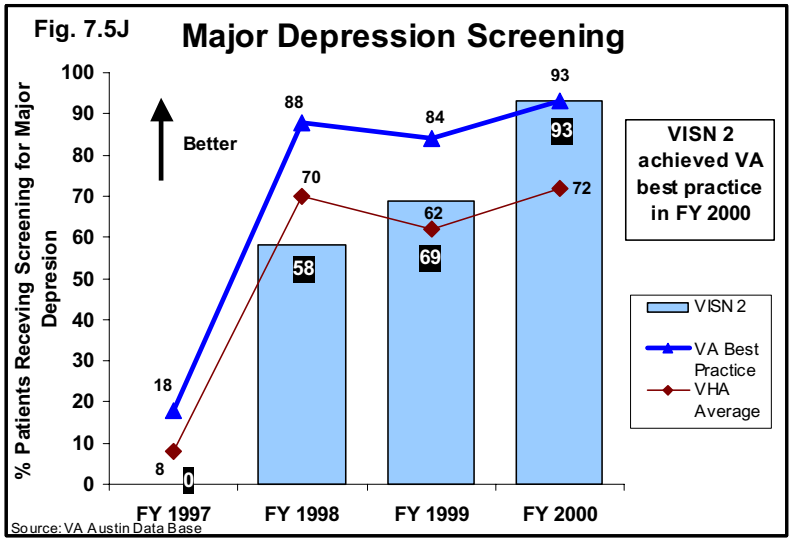


2002.

I. Cervical Cancer Screening (Key Driver-Quality)

The percentage of patients receiving cervical cancer screening improved to 92% in FY 2000, surpassing community-screening rates of 70-74% *(National, Mid-Atlantic & MVP Health Plan).* **Evaluation & Improvement of Processes:** Senior leaders and Medical VA Care line staff review reports on a monthly basis, and have issued procedural improvements, leading to improved performance. VISN 2 has developed a targeted score of 97% by 2002

Fig. 7.5J



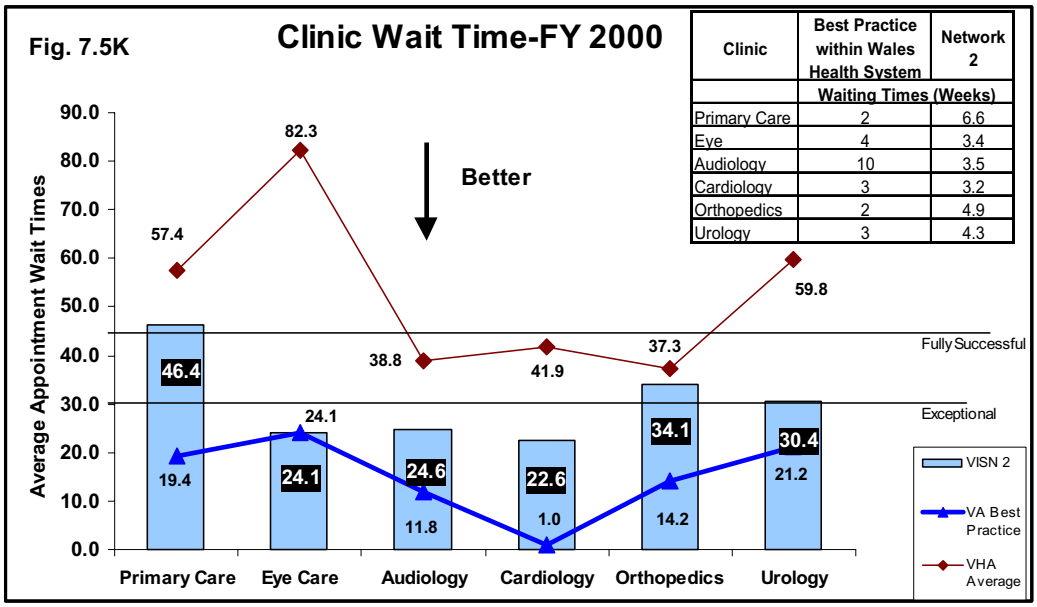
J. Major Depression Screening (Key Driver-Quality)

The percentage of patients receiving required intervention in the form of screening for major depression improved to **93%** in FY 2000, **achieving VA best practice**. ***Evaluation & Improvement of Processes*** Senior leaders and Behavioral Health Care line staff review reports on a monthly basis, and have issued procedural improvements.

K. Waiting Times for Clinics-(Key Driver-Customer Service)

Average waiting times for 6 clinics have continued to improve with 3 clinics surpassing the VA exceptional levels, with Eye Care clinic achieving VA best practice. ***Evaluation & Improvement of Processes:*** Senior leaders and front line staff review clinic waiting times, introducing scheduling improvements. Aggregated results demonstrate that VISN 2 waiting times were **40.75% less** than the VHA mean, the 3rd best performance to VISN 19 Denver (–45.62%) and VISN 2 Baltimore (-43.05%).

Fig. 7.5K



Clinic	Best Practice within Wales Health System	Network 2
	Waiting Times (Weeks)	
Primary Care	2	6.6
Eye	4	3.4
Audiology	10	3.5
Cardiology	3	3.2
Orthopedics	2	4.9
Urology	3	4.3

GLOSSARY OF TERMS

TERM	DEFINITION
360 Degree Evaluation	Personal and professional tool aligned with core competencies of the High Performance Development Model; provides feedback from supervisor, peers and subordinates
6 for 2006	6 VHA strategic goals to be reached by 2006
ADHC	Adult Day Health Care-A Day Care program providing an alternative to hospitalization for extended care patients
Alternate Revenue	Funding acquired outside of the federal appropriations process including collections from insurance carriers and private payers; sharing agreements
BVAHC	Behavioral VA Health Care Line
Care Lines	Organizational units through which patients are treated throughout Network 2 (Medical VA Care, Behavioral VA Health Care, Geriatrics & Extended Care, Diagnostics & Therapeutics, Mgmt Systems
Category A	Veterans below a specified income threshold (Medically Needy)
CBOC	Community Based Outpatient Clinic –operated through VA staff or through contract with provider
CDI	Chronic Disease Index The index consists of 13 clinical interventions that assess how well VHA follows nationally recognized guidelines for 5 high volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, (COPD) diabetes mellitus, obesity
Clinical Practice Guideline (CPG)	Set of clinical protocols to aid in patient care decisions
Comping	The comping program is an integral part of customer service, and particularly service recovery. It is the series of actions that a staff member can take to turn a negative customer service event into a *positive, memorable* one
Complex Patients	Patients who require specialty care services, often on a chronic basis
CQI	Continuous Quality Improvement
CSC	Customer Service Council
D & T	Diagnostics and Therapeutics Care Line (Pharmacy, Laboratory, Radiology, Audiology, Phys. Medicine & Rehab)
DRG	Diagnosis Related Groups-A classification of clinically similar patients based upon inpatient diagnoses
DSO	Decision Support Objects provide desktop access to key performance measure and operational data
ELC	Executive Leadership Council-the equivalent of the Governing Body within Network 2 Establishing Organizational Mission, Responsible for both Tactical and Long Range Objectives, Issues Required Action, Evaluates Organizational Performance
FTEE	Full Time Employee Equivalents-the unit of staffing measure within VHA
GEC	Geriatrics & Extended Care Line
HBPC	Home Based Primary Care-program through which staff visit extended care patients in the home, providing primary care services
HPDM	High Performance Development Model-designed to promote staff development in accordance with changing skill requirements
Internal Shopper Program	The Internal Shopper Program is a customer service initiative designed to focus on the expectations of our customers as seen through the eyes of a fellow VA employee
JCAHO	Joint Commission on Accreditation of Health Care Organizations
KBD	Key Business Drivers are factors / areas deemed crucial to organizational success
Local Leadership Committee LLC	Counterpart to the ELC at the local level for coordinating Network and care line requirements
MAC	Management Assistance Council is a forum for obtaining stakeholder feedback

Market Penetration	Percentage of veterans treated in a specific locality
MCCF	Medical Care Collection Fund-Alternate revenue collected from patients, insurance carriers
Mental Health Follow-Up	Patients who receive outpatient care related to mental health within 30 days following discharge.
MVAC	Medical VA Care Line (Medicine, Surgery, Primary Care)
NAO	Network Authorization Office-organizational unit established to improve patient transfers, emergency care access and treatment at non-VA facilities
Network	One of 22 organizational units (Veterans Integrated service Networks (VISNs) which constitute the VA Health Care System
NHCU	Nursing Home Care Unit-VA-operated skilled-nursing care unit
NRM	Non-Recurring Maintenance Projects
NSC	Non-Service Connected Patient
Picker Institute	Compilation of data from 50 industry leaders in customer service
Prevention Index (PI)	Prevention Index -consists of 9 clinical interventions that measure how well VHA follows nationally recognized primary prevention and early detection recommendations for 8 diseases with major social consequences: influenza and pneumococcal diseases, tobacco use, alcohol abuse, cancer of the breast, cervix, colon, and prostate
Priority Groups	Classification of Veterans categorized for enrollment purposes from 1 through 7, based upon degree of service connection, income and other factors
PTSD	Post Traumatic Stress Disorder
Pulse Points	Monthly report of performance measure performance
Quick Card	Customer survey program that provides immediate feedback
SC	Service Connected Patient
SCI	Spinal Cord Injury
SMI	Seriously Mentally Ill
Special Disability Programs	Programs provided for 6 special populations of disabled veterans : Amputation, Blindness, PTSD, Serious Mental Illness, Spinal Cord & Traumatic Brain Injury
Special Emphasis programs	Programs that uniquely characterize VA health care including Addictive Disorders, Homeless, Prosthetics, Gulf War, Former POW, Ionizing Radiation, etc.
Telemedicine	Advanced technology applying high-powered video cameras to assist in patient diagnosis and treatment from remote locations
TSPQ	Transforming Systems Performance & Quality Council (TSPQ)Responsible for Network Operations Coordinates VISN-Wide Actions & Priorities Operationalizes Network Strategic Goals
Unique Patients	The number of individual (unduplicated) patients treated
VERA	Veterans Equitable Resource Allocation Model-methodology through which VHA appropriations are distributed among 22 networks
VHA / VA	Veterans Health Administration / Veterans Affairs
Virtual Help Desk	Computerized medium through which VA customers may request on-line information through the Network 2 Web Page.
VISN	Veterans Integrated Service Network -One of 22 organizational units which constitute the VA Health Care System
VSC	Veterans Service Centers are designed to provide "one-stop shopping" for veterans, by providing a central point at each of our Medical Centers for helping veterans and guests with questions about accessing VA Healthcare, VA Healthcare benefits, eligibility determination, billing questions, obtaining a Veterans Identification Card and general questions.
VSO	Veterans Service Organization